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SURGERY OF THE HEART AND ALLIED GREAT VESSELS

Chairman's Address

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The purpose of this paper is to present in concise form the status of surgery of the heart and associated great vessels. I do not plan to go into actual details of surgical technic, but rather to give an idea of what can be accomplished by operation in various cardiac conditions. Some of the surgical approaches to problems of heart disease are not new but advances of note have been made in them. A new chapter in surgery is being written in the management of certain congenital diseases of the heart, and is of such importance that it should be forcibly brought to the attention of the profession. Only by surgical means can patients with certain conditions formerly considered hopeless be offered a good chance for cure, and this opportunity should not be denied them. The subjects for discussion will be taken up as outlined.

I. Heart
  A. Disease
    1. Acute suppurative pericarditis
    2. Chronic constrictive pericarditis
    3. Coronary sclerosis
  B. Injuries
    1. Nonpenetrating
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    3. Retained foreign bodies
  C. Tumors
II. Allied great vessels
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    1. Patent ductus arteriosus
    2. Coarctation of the aorta
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ACUTE SUPPURATIVE PERICARDITIS

Prior to the general use of penicillin about 1944 the sole chance of recovery in cases of suppurative pericarditis lay in surgical drainage, and then as now the best prognosis was afforded by early operation—an end rarely achieved since this disease is usually not recognized until late. Behrend and Boles reported that of 146 cases of acute purulent pericarditis coming to autopsy at the Philadelphia General Hospital the disease had been diagnosed in only 4, and 3 had come to operation.[1]

Surgical drainage has been effected by various approaches, the most frequently used being an anterior one in which portions of one or more costal cartilages and a portion of the sternum are resected. Every effort must be made to evacuate the pus which is so prone to collect in the sulcus behind the heart and to prevent its reaccumulation either by the introduction of tubes with gentle irrigation or by the daily exploration of this area with the lubricated gloved finger; whereas the mortality rate in cases of suppurative pericarditis not treated surgically is 100 per cent, roughly 50 per cent of patients treated by surgical drainage have recovered.[2]

What is the role of chemotherapy in the management of suppurative pericarditis? From a prophylactic point of view, a decided decrease in incidence should be effected, since the disease is never primary but always secondary to infections elsewhere, such as empyema, infected wounds, pneumonia and septicemia from various causes, especially osteomyelitis, all of which are so favorably influenced by chemotherapy. The systemic use of chemotherapeutic agents alone in established cases of suppurative pericarditis has been extremely disappointing. A careful analysis of the few reports available dealing with pericardial paracentesis followed by the introduction of penicillin would indicate that this method of treatment is open to serious question, and in my own mind is not to be recommended.[3] The two chief objections to it are (1) the inherent danger of injuring the heart with the needle, a fact particularly to be reckoned with in this disease in which the heart is so commonly "floated" against the anterior pericardium and may even be adherent there, and (2) the impossibility of removing by aspiration performed anteriorly the pus which uniformly collects behind the heart. The proper place for chemotherapy would appear to be as an adjunct to surgical drainage, when it should be employed systemically in large doses and locally in the pericardial sac after the latter has been surgically exposed and when the drug may be placed in all portions of the pericardial cavity under direct

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Read before the Section on Surgery at the Ninety-Seventh Annual Session of the American Medical Association, Chicago, June 24, 1948.

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1. Behrend, M., and Boles, R. S.: Indications for Operations of Cardiolysis, Pericardiostomy and Pericardiectomy, J. A. M. A. **108**:1941-1946 (June 5) 1937.

2. (*a*) Bigger, I. A.: Suppurative Pericarditis, Ann. Surg. **109**:763-770, 1939. (*b*) Bunch, G. H.: Suppurative Pericarditis, Am. J. Surg. **28**:613, 1935. (*c*) Gowland, M. M.: Local Penicillin in Purulent Pericarditis, Brit. M. J. **2**:922, 1947. (*d*) Guiou, N. M.: Pericardiotomy for Septic Pericarditis, Canad. M. A. J. **41**:163-166, 1939. (*e*) Impink, R. R.; Deuhoff, E., and VanderVeer, J. B.: Staphylococcus Aureus Septicemia, with Osteomyelitis, Pneumonia, and Acute Purulent Pericarditis, Am. Heart J. **36**:699-708, 1943. (*f*) Ross, D. E.: Suppurative Pericarditis, Am. J. Surg. **43**:134-137, 1939. (*g*) Shipley, A. M.: Suppurative Pericarditis, Ann. Surg. **103**:698-705, 1936. (*h*) Shipley, A. M., and Winslow, N.: Purulent Pericarditis, Arch. Surg. **31**:373-394 (Sept.) 1935. (*i*) VanderVeer, J. B., and Wagner, J. A.: Diagnosis and Treatment of Acute Pericarditis, Clinics **5**:96-113, 1946. (*j*) Wadsworth, G. L.: Symposium on Surgical Infections: Acute Pericarditis, S. Clin. North America **22**:432-436, 1942.

3. Allison, S. T., and Loughlin, E. H.: Acute Pericarditis Successfully Treated with Intrapericardial Penicillin and Systemic Chemotherapy, U. S. Nav. M. Bull. **44**:383-386, 1945. Smalley, R. E., and Ruddock, J. C.: Acute Pericarditis: Study of Eighteen Cases Among Service Personnel, Ann. Int. Med. **25**:799-812, 1946. Texon, M.: Purulent Pericardial Effusion, Am. J. Med. **1**:577-580, 1946. Wadsworth.[2j] Wise, A. W., and Shafer, L. E.: Purulent Pericardial Effusion Treated with Penicillin Given Intrapericardially, J. A. M. A. **127**:583 (March 10) 1945. Zimmerman, J. J., and Durgin, B.: Staphylococcus Aureus Septicemia and Pericarditis Treated with Penicillin, Am. Heart J. **31**:93-97, 1946.

vision. Today in the established disease the most effective treatment is early surgical drainage supplemented by intensive systemic and local penicillin therapy.

CHRONIC CONSTRICTIVE PERICARDITIS

Although the medical treatment of chronic constrictive pericarditis is often palliative it is never curative, and with such therapy alone this disease always kills. The surgical attack on the condition is relatively recent. Churchill's patient, operated on July 18, 1928, was the first successfully treated patient in the United States.[4] Since that time the operation has been performed by many surgeons, with decreasing mortality rates and more gratifying results.

As experience with this disease has widened, certain facts have become increasingly evident. Tuberculosis has assumed a more prominent role in the causation.[5] It has been found unwise to operate while the inflammatory condition is active unless it is obvious that death will otherwise ensue. The most reliable signs now recognized are: high venous pressure, low arterial pressure, a quiet fixed heart, paradoxic pulse, an enlarged liver, with ascites followed by edema of the lower extremities, and fluid in the pleural cavity.[6] The diagnosis has many times been confused with cirrhosis of the liver, principally on account of the ascites. From a technical point of view there have been few changes in the operation itself, which consists of the removal of a portion of the thickened adherent pericardium. A recent modification in technic has been effected by utilizing a direct intrapleural approach after resection of the fifth rib and division of two or more costal cartilages. This procedure is easier and less mutilating than the formerly preferred method of an extrapleural approach with resection of the second to sixth costal cartilages together with short segments of the ribs and occasionally a portion of the sternum. Much emphasis is placed by Heuer [7] on adequate preoperative preparation, consisting of bed rest, restoration of protein balance and removal of fluid by diuretics and aspiration, even though this takes many weeks.

Owing to atrophy from disuse and also to myocardial degeneration, in long-standing cases the heart does not recover for many months or may always show impaired function. For this reason, as well as on account of permanent hepatic damage that may result in neglected cases, early diagnosis and prompt operation are essential for full recovery.

In general it may be stated that results of operation in the disease are as follows: 61.5 per cent of the patients are cured or decidedly improved and 9.5 per cent unimproved; the mortality rate, which varies from 29 per cent to 0 per cent, has declined strikingly in the last decade. The most recent comprehensive report is by Heuer, who in 1946 cited 18 personal cases with no deaths and 83 per cent of the patients cured or considerably improved.[7]

CORONARY SCLEROSIS

The vast majority of deaths due to "heart disease" result from diminished blood flow through the coronary arteries. It follows, therefore, that any method of supplementing and increasing coronary circulation would be of great value in the management of this disease. Studies have indicated that in coronary artery sclerosis the larger branches are involved first, often to the exclusion of the smaller ones. This should provide an ideal arrangement for the efficacy of anastomoses between an outside source and the smaller coronary branches which nourish the myocardium.

The essential factors involved in the production of an adequate collateral circulation are to provide an adequate source of blood and to produce an anastomosis between this source and the myocardial vessels. The actual anastomosis has been attempted by the production of vascular granulation tissue between the heart muscle and the intended new blood supply. It has been postulated that newly formed vessels in this tissue would join with existing vessels in the donor and recipient sites and thus provide new channels by which blood could reach the myocardium. Considerable reliance has been placed on the fact that when an organ is in need of blood, it avails itself of any possible source of supply. Experimental and clinical attempts to produce vascular granulation tissue through which a collateral blood supply can reach the myocardium have been by scarification of opposing surfaces and by the use of irritating substances, such as talc, powdered asbestos and acriflavine. Potential sources of new blood supply which have been utilized are the thoracic wall, including the pectoral muscles and the internal mammary and intercostal arteries, the pericardium together with its fat, the omentum and the lung. It has been definitely demonstrated experimentally that new vascular channels can be established between the heart and an outside source, but the direction of blood flow has not been proved, nor the volume of blood which can be supplied, nor the duration of the newly formed channels. Evaluation of any method is notoriously difficult in view of the remarkable improvement which nature alone sometimes effects in coronary disease.

In 1935 Claude Beck published his first paper dealing with the production of collateral blood supply to the heart, and his painstaking and fundamental work since that time has been of outstanding importance. He first sutured flaps of pectoral muscle to the abraded heart surfaces, but in subsequent operations abandoned this procedure in favor of the introduction of powdered asbestos, leaving windows in the anterior pericardium through which vascular connections could be established between the cardiac muscle and the thoracic wall.[8] From 1935 to his last published report in 1943 he had operated on 37 patients, with an operative mortality rate of 37.8 per cent.[8g] Of the survivors 14 were cured or greatly improved, 5 were moderately improved and 4 were unimproved. In May 1948 he reported the results of studies on anastomosing the aorta to the coronary sinus by way of a transplanted vessel, first ligating

4. Churchill, E. D.: Decortication of the Heart for Adhesive Pericarditis, Arch. Surg. **19**: 1457-1469 (Dec., pt. 2) 1929.

5. Blalock, A., and Levy, S. E.: Tuberculous Pericarditis, J. Thoracic Surg. **7**: 132-149, 1937. Harrington, S. W.: Chronic Constrictive Pericarditis: Partial Pericardiectomy and Epicardiolysis in Twenty-Four Cases, Ann. Surg. **120**: 468-487, 1944. Blalock, A., and Burwell, C. S.: Chronic Pericardial Disease, Surg., Gynec. & Obst. **73**: 433-461, 1941.

6. Beck, C. S.: Acute and Chronic Compression of Heart, Am. Heart J. **14**: 515-525, 1937.

7. Heuer, G. J., and Stewart, H. J.: The Surgical Treatment of Chronic Constrictive Pericarditis, S. Clin. North America **26**: 477-488, 1946.

8. (a) Beck, C. S.: The Development of a New Blood Supply to the Heart by Operation, Ann. Surg. **102**: 801-813, 1935. (b) Beck, C. S., and Tickry, V. L.: The Production of a Collateral Circulation to the Heart, Am. Heart J. **10**: 849-872, 1935. (c) Beck, C. S.: Further Data on the Establishment of a New Blood Supply to the Heart by Operation, J. Thoracic Surg. **5**: 604-611, 1936. (d) Beck, C. S.: Coronary Sclerosis and Angina Pectoris: Treatment by Grafting New Blood Supply upon the Myocardium, Surg., Gynec. & Obst. **64**: 270-272, 1937. (e) Beck, C. S.: The Coronary Operation, Am. Heart J. **22**: 539-544, 1941. (f) Beck, C. S.: Principles Underlying the Operative Approach to the Treatment of Myocardial Ischaemia, Ann. Surg. **118**: 788-806, 1943. (g) Feil, H., and Beck, C. S.: Coronary Sclerosis and Angina Pectoris: Thirty Patients Treated by Beck Operation, J. Thoracic Surg. **10**: 529-540, 1941. (h) Schildt, P.; Stanton E., and Beck, C. S.: Communications Between the Coronary Arteries Produced by Application of Inflammatory Agents to the Surface of the Heart, Ann. Surg. **118**: 34-45, 1943. (i) Stanton, E.; Schildt, P., and Beck, C. S.: The Effect of Abrasion of the Surface of the Heart upon Intercoronary Communications, Am. Heart J. **22**: 529-544, 1941.

the coronary sinus.[9] After a considerable number of animal experiments the procedure was carried out on a patient, a portion of the branchial artery being used for the graft.

In 1938 O'Shaughnessy of England, utilizing omentum brought up through the diaphragm as a source of blood supply, operated on 20 patients, with 6 deaths. Nine of the survivors were asymptomatic. Since his tragic death in the battle of Dunkirk his work has not been continued.[10]

Thompson and Raisbeck in 1942 utilized talc to produce vascular adhesions between the heart and pericardium.[11] Thompson's latest report comprised 38 patients with good results in 70 per cent and a 15.8 per cent mortality rate.[12]

Fauteux has attempted to relieve anginal pain by pericoronary neurectomy combined with ligation of the coronary sinus to increase the amount of blood available to the myocardium. His clinical cases at his last report (1946) numbered 16, with 3 operative deaths.[13] Eleven patients were alive with objective improvement three months to six and a half years after operation. More recently he published studies on anastomosis of the internal mammary artery with the coronary sinus and anastomosis of the right auricle with the pulmonary artery above the pulmonary valves, but no clinical data were given.[14]

Vineberg (1946, 1948) has reported experimental studies on the production of vascular anastomoses through implantation of the internal mammary artery directly into the myocardial wall of the left ventricle. There has been no clinical application of these studies.[15]

Lezius in 1939 utilized the lung experimentally as a source of blood to the heart.[16] O'Shaughnessy used this procedure in 1 patient with decided improvement. I have modified Lezius' operation and, after considerable experimental work in which undoubted numerous new vascular channels were demonstrated, have operated on 2 human beings. One of these patients, operated on one year ago, is decidedly improved, and the other died of a massive infection thirty-six hours after operation.

In attempting to evaluate the results of the clinical efforts at producing a collateral blood supply to the heart, I find it striking that, in spite of apparent improvement in the majority of surviving patients, reporting surgeons have not published further experiences with the operation and that their lead has not been followed by others. The solution of the problems involved is of so great potential therapeutic value that it justifies the continuation of the combined efforts of cardiologists and surgeons. In my opinion careful clinical application of the principles worked out in the laboratory is not only justifiable but is indicated if progress is to be made in this field.

NONPENETRATING WOUNDS OF THE HEART

There is no question that the heart may be damaged by nonpenetrating injuries, such as direct blows over the precordium, compression of the thorax and sudden compression of the abdomen and lower extremities. Beck has emphasized the importance of "steering wheel accidents" in this regard and other authors have reported cardiac damage caused by blows from baseballs and fists and by compression by trailer bars, tail gates of trucks and the like.[17] The damage produced in the heart varies from actual rupture to mild contusion. The signs and symptoms of injury to the heart are frequently unrecognized, since they are masked by the evident injury to the bony thorax. They are precordial pain, tachycardia, arrhythmia, dyspnea and roentgenologic and electrocardiographic changes. The heart is capable of withstanding considerable trauma, and the vast majority of patients sustaining moderately severe cardiac injury recover, provided that the injury is recognized and the medical treatment employed is similar to that in myocardial infarction. There is, however, a group of cases in which surgical intervention is indicated and is life saving. These cases include those (1) in which a small rupture of the heart muscle occurs, accompanied with hemorrhage into the pericardial sac with a resulting acute compression of the heart, (2) in which acute cardiac compression occurs from the accumulation of large amounts of bloody fluid without actual rupture of the myocardium and (3) in which softening and fibrosis of a contused area results in the formation of an aneurysm. If signs and symptoms of acute cardiac compression are evident immediately or within a short time after injury, rupture of the heart should be suspected and immediate operation performed with evacuation of blood and clot and suture of the laceration. If such signs and symptoms develop more gradually over a period of hours or days, it is logical to assume that no actual rupture has occurred but that bloody fluid has accumulated from a contusion. In such circumstances aspiration is preferable, since there is little likelihood of an actively bleeding point. In instances in which aneurysm of the heart is developing, the involved area may be reinforced with a patch of fascia lata or pericardium. A more definitive surgical approach would be excision of the aneurysm, and this may well be feasible in view of Murray's successful resection of acutely infarcted areas in dogs' hearts and of my own experience of successful removal of considerable areas of both normal and infarcted heart muscle in animals.[18]

PENETRATING WOUNDS OF THE HEART

Prior to 1933 the vast majority of cases with penetrating wounds of the heart were either unrecognized or treated conservatively, with a mortality rate of 90

9. Beck, C. S.: Stanton, E.; Batiuchok, W., and Leiter, E.: Revascularization of Heart by Graft of Systemic Artery into Coronary Sinus, J. A. M. A. **127**: 436-442 (May 29) 1948.

10. Davies, D. T.; Mansell, H. E., and O'Shaughnessy, L.: The Surgical Treatment of Angina Pectoris and Allied Conditions, Lancet **1**: 1-10 and 76-82, 1938. O'Shaughnessy, L.: Surgical Treatment of Cardiac Ischaemia, Lancet **1**: 185-194, 1937. O'Shaughnessy, L.; Slome, D., and Watson, F.: Surgical Revascularization of the Heart, Lancet **1**: 617-621, 1939.

11. Thompson, S. A., and Raisbeck, M. J.: Cardio-Pericardiopexy: The Surgical Treatment of Coronary Artery Disease by the Establishment of Adhesive Pericarditis, Ann. Int. Med. **16**: 495-520, 1942.

12. Thompson, S. A., in discussion on Stanton, Schlidt and Beck [9] at American Surgical Association, May 1948.

13. Fauteux, M.: Experimental Study of the Surgical Treatment of Coronary Disease, Surg., Gynec. & Obst. **71**: 151-155, 1940. Fauteux, M.: Treatment of Coronary Disease with Angina by Pericoronary Neurectomy Combined with Ligation of the Great Cardiac Vein, Am. Heart J. **21**: 260-269, 1946. Fauteux, M.: Surgical Treatment of Angina Pectoris, Ann. Surg. **124**: 1041-1046, 1946.

14. Fauteux, M.: Anastomosis of the Right Auricle with the Pulmonary Artery, Rev. canad. de biol. **5**: 252, 1946. Fauteux, M.: Anastomosis of the Internal Mammary Artery with the Coronary Sinus, Rev. canad. de biol. **5**: 252, 1946.

15. Vineberg, A. M.: Development of Anastomosis Between Coronary Vessels and Transplanted Internal Mammary Artery, Canad. M. A. J. **55**: 117-119, 1946. Vineberg, A. M.: Development of Anastomosis Between Coronary Vessels and Transplanted Internal Mammary Artery, read before the American Association for Thoracic Surgery, June 2, 1948.

16. Lezius, A.: Die anatomischen und funktionellen Grundlagen der künstlichen Blutversorgung des Herzmuskels durch die Lunge bei Coronararterienverschluss, Arch. f. klin. Chir. **191**: 101-139, 1938.

17. Beck, C. S.: Contusions of the Heart, J. A. M. A. **104**: 109-114 (Jan. 12) 1935.

18. Murray, G.: The Pathophysiology of the Cause of Death from Coronary Thrombosis, Ann. Surg. **126**: 523-534, 1947.

per cent or more. With a better understanding of the problems involved has come a more precise method of surgical management and a mortality rate ranging from 22 to 49 per cent in those clinics in which a considerable number of cases are encountered. At the Cincinnati General Hospital there has been a 21 per cent mortality rate in 29 patients. There is evidence that mortality figures are being lowered even more; Griswold reports only 3 deaths in the last 36 cases from his clinic.[19]

The diagnosis is as a rule easy, provided that the possibility of heart injury is ever kept in mind. Such diagnosis is based primarily on the signs and symptoms of acute compression of the heart resulting from bleeding into the pericardial sac. Beck has emphasized a triad of signs of fundamental importance: elevated venous pressure (normal being 6 to 12 cm. of water), a lowered arterial pressure and a quiet heart. In addition there is shock out of proportion to the apparent injury and fluoroscopic evidence of diminished or absent cardiac pulsation.

As experience with this condition has accumulated there has come a recognition that not all patients sustaining penerating heart wounds need be subjected to operation. The selection of cases for conservative treatment requires delicate judgment combined with critical and continued observation. Several important factors enter into this crucial and hazardous decision. If the causative agent is one apt to produce a small wound in the heart which therefore does not tend to bleed furiously or continuously, aspiration should be curative. Such agents are ice picks, small-bladed knives and long pins. On the other hand, bullets and large-bladed knives are prone to produce large lacerations of the heart which require operation and suture. A slow onset of the signs and symptoms of acute cardiac compression after injury indicates a small heart laceration with little tendency to rapid or continuous bleeding. Patients with bleeding from a heart wound into the pleural cavity can be saved only by operation. Singleton,[20] Strieder,[21] Griswold,[22] Warren and his co-workers [23] and Blalock and Ravitch [24] have reported successful treatment in carefully selected cases by aspiration, but all emphasize the necessity of performing aspiration with the operating room in readiness if aspiration is not successful because of clot, in the presence of clearcut signs of cardiac compression, or if there is evidence of recurrence of compression. Aspiration is of unquestionable benefit as a life-saving measure in patients who might well succumb to pronounced cardiac compression before operation can be performed.

Beck in 1942 [25] and Cooper, Stead and Warren [26] in 1944 have demonstrated the real value of intravenous infusions of isotonic sodium chloride solutions and blood as a preliminary to either conservative or operative treatment where there is cleancut evidence of acute cardiac compression.

19. Maguire, C. H., and Griswold, R. A.: Further Observations on Penetrating Wounds of the Heart and Pericardium, Am. J. Surg. **74**: 721-731, 1947.

20. Singleton, A. O.: Wounds of the Heart, Am. J. Surg. **20**: 515-541, 1933.

21. Strieder, J. W.: Stab Wound of the Heart, J. Thoracic Surg. **8**: 576-577, 1939.

22. Griswold, R. A., and Maguire, C. H.: Penetrating Wounds of Heart and Pericardium, Surg., Gynec. & Obst. **74**: 406-418, 1942. Maguire and Griswold.[19]

23. Warren, J. V.; Brannon, E. S.; Stead, E. A. Jr., and Merrill, A. G.: Pericardial Tamponade from Stab Wound of Heart and Pericardial Effusion or Empyema, Am. Heart J. **21**: 418-425, 1946.

24. Blalock, A., and Ravitch, M. M.: A Consideration of the Nonoperative Treatment of Cardiac Tamponade Resulting from Wounds of the Heart, Surgery **14**: 157-162, 1943.

25. Beck, C. S.: Further Observations on Stab Wounds of the Heart, Ann. Surg. **115**: 698-704, 1942.

26. Cooper, P. W., Jr.; Stead, E. A., Jr., and Warren, J. V.: The Beneficial Effect on Intravenous Infusion in Acute Pericardial Tamponade, Ann. Surg. **120**: 822-825, 1944.

RETAINED FOREIGN BODIES

One of the most thrilling and spectacular advances in cardiac surgery resulting from experiences in World War II is that of removal of foreign bodies from the chambers of the heart and from the lumen of the nearby great vessels. Prior to the war there was some difference of opinion as to the advisability of the removal of such foreign bodies, but a majority of observers favored treatment without operation. Factors which have served to reverse this attitude have been the relatively large number of such cases occurring in military surgery and surgical confidence stemming from improved operative technics combined with perfected methods of anesthesia. Harken and his associates have been the leaders in this field, and their phenomenal success is directly responsible for the present attitude that foreign bodies measuring 1 cm. or more in two dimensions should be removed surgically.[27] The proved reasons for such removal are: (1) to prevent embolism, (2) to diminish the danger of bacterial endocarditis and (3) to decrease the incidence of myocardial or vessel wall damage leading to possible rupture with hemorrhage. In addition, the distressing symptoms of precordial pain, dyspnea, asthenia and cardiac neurosis can be relieved by operation.

Harken's results are as follows: 134 patients with foreign bodies in and in relation to the thoracic blood vessels and heart were operated on without a death. In 13 of these patients, foreign bodies were removed from cardiac chambers.[27a]

PRIMARY TUMORS OF THE HEART

Primary tumors of the heart are infrequently encountered, the estimated ration of primary to metastatic lesions being 1:16. Woll and Vickery cite Maheim as having collected 320 cases of primary tumors of the heart to 1945, the disease in only 3 of which had been diagnosed ante mortem.[28] These lesions are usually clinically silent. Roentgenologic examination may reveal a fixed right border, or the size and shape of the heart may be abnormal. Unexplained and sometimes inconstant changes in cardiac rhythm and the development of hemorrhagic pericardial effusion are suggestive of a tumor of the heart.

The chambers of the heart are usually extensively involved in primary tumor, over 50 per cent occurring on the left side.[29] Rarely are these lesions so situated as to be amenable to surgical removal even when properly diagnosed. The only recorded case with successful operative removal is that of Beck, who in 1942 reported a patient with an unidentified type of calcified lesion on the left ventricular wall.[30]

PATENT DUCTUS ARTERIOSUS

Although some patients with patent ductus arteriosus live out their life span in comparatively good health, the vast majority succumb to complications of the

27. Harken, D. E.: The Removal of Foreign Bodies from the Pericardium and Heart, J. Thoracic Surg. **16**: 701-709, 1947. (b) Harken, D. E.: Foreign Bodies in, and in Relation to, the Thoracic Blood Vessels and Heart, Surg., Gynec. & Obst. **83**: 117-125, 1946. (c) Harken, D. E., and Zoll, P. M.: Foreign Bodies in and in Relation to Thoracic Blood Vessels and Heart, Am. Heart J. **33**: 1-19, 1946.

28. Woll, E., and Vickery, A. L.: Primary Fibrosarcoma of the Heart with Vertebral Metastases, Arch. Path. **45**: 244-252 (March) 1947.

29. Yater, W.: Tumors of the Heart and Pericardium, Arch. Int. Med. **48**: 627-666 (Oct.) 1931.

30. Beck, C. S.: Intrapericardial Teratoma and Tumor of Heart, Both Removed Operatively, Ann. Surg. **116**: 161-174, 1942.

disease within the first three decades. These complications are cardiac decompensation, as a result of the increased load thrown on the heart; bacterial endarteritis, usually due to Streptococcus viridans infection occurring on the plaques produced in the pulmonary artery by the swirl of the blood and increased arterial pressure in the artery; rupture of the thinned duct or pulmonary artery, and thrombosis with embolism. Shapiro and Keys after careful study concluded that 80 per cent of the patients with patent ductus arteriosus eventually succumbed to their lesion; of these, 40 per cent died of subacute bacterial endarteritis while the remainder, except for a few deaths due to rupture of the ductus or pulmonary artery, died of congestive cardiac failure.[31] In view of these observations they reversed their previous conservative attitude and made a statement representative of the best present day opinion: "Surgery is advisable in the great majority of patients with patent ductus arteriosus with or without subacute bacterial endarteritis. In the latter case surgery affords more than a forlorn hope. The uninfected patient cannot expect a normal life span without surgery and is liable to develop subacute bacterial endarteritis at any time in spite of apparent well being." Signs and symptoms of patent ductus include "machinery" murmur accented during systole, thrill over the pulmonic area, hilar dance and prominent left pulmonary artery.

Great credit is due Gross for his performance in August 1938 of the first successful ligation of a patent ductus arteriosus and for his fundamental contributions to this subject.[32] An increasing number of surgeons have performed the operation until it is now widely practiced with excellent results. Touroff has emphasized the curative value of the operation for patent ductus arteriosus complicated by subacute bacterial endarteritis, a condition at one time considered a contraindication to operation.[33] Prior to the advent of penicillin the operation alone proved curative in about one half of such cases. The use of penicillin has greatly widened the field for operation in cases with infection, has materially reduced mortality rates and has increased the chance for cure. It is of particular value in preparing these desperately ill patients for operation as well as in their subsequent treatment.

Gross first advocated simple ligation of the duct. Owing to 20 per cent incidence of recanalization following ligation in continuity, he now divides the duct between clamps and sutures the cut ends. It seems fair to state that ligation is satisfactory in about 80 per cent of the cases, whereas division completely precludes recanalization and is the more surgical procedure.

The following figures indicate what can be expected of the operation: Gross reported ligation of the ductus in 43 patients with 3 deaths and complete division in 90 patients with 2 deaths.[32d] In Jones' series of fifty-three ligations and eight divisions there were 2 deaths.[34]

31. Shapiro, M. J., and Keys, A.: Prognosis of Untreated Patent Ductus Arteriosus and Results of Surgical Intervention, Am. J. M. Sc. **200**: 174-183, 1943.

32. (*a*) Gross, R. E., and Hubbard, J. P.: Surgical Ligation of a Patent Ductus Arteriosus, J. A. M. A. **112**: 729-731 (Feb. 25) 1939. (*b*) Gross, R. E.: Surgical Therapy in Ten Cases of Patent Ductus Arteriosus, J. A. M. A. **113**: 1257-1262 (Oct. 12) 1940. (*c*) Gross, R. E.: Complete Surgical Division of Patent Ductus Arteriosus, Surg., Gynec. & Obst. **78**: 36-43, 1944. (*d*) Gross, R. E.: Complete Division for the Patent Ductus Arteriosus, J. Thoracic Surg. **16**: 314-327, 1947.

33. Touroff, A. S. W.: A Modified Technic of Surgical Ligation of Patent Ductus Arteriosus, Surgery **12**: 24-30, 1942. Touroff, A. S. W.: Further Experiences in the Treatment of Subacute Streptococcus Viridans Endarteritis Superimposed on Patent Ductus Arteriosus, J. Thoracic Surg. **12**: 1-17, 1942.

34. Jones, J. G.: Complications of the Surgery of Patent Ductus Arteriosus, J. Thoracic Surg. **16**: 303-313, 1947.

COARCTATION OF THE AORTA

Coarctation of the aorta has been known for two hundred years and is commoner than is usually recognized. For example, Abbott found 142 cases among 1,000 instances of congenital cardiovascular defects and stated that the average age at death was 36 years.[35] The fibrosed constriction in the aorta is located just beyond the site of origin of the left subclavian artery and produces from slight to complete obstruction. The most important diagnostic sign is hypertension in the upper portion of the body with hypotension in the lower, as evidenced by diminished or absent femoral pulses. It is imperative that this condition be ruled out in all cases of hypertension, especially in children. Additional evidences of the disease are cardiac hypertrophy, absence of the aortic knob, scalloping of the ribs from pressure of the dilated intercostal arteries and palpation of pulsating arteries on the thoracic wall, particularly in the interscapular region when the patient bends forward. The chief dangers of the condition are those of hypertension, others result from aneurysm of the aorta, with or without dissection and rupture, and S. viridans endarteritis.

In October 1944 Crafoord of Stockholm performed the first successful operation for relief of this condition.[36] He resected the coarcted portion of the aorta between clamps and performed end to end suture. In this country Gross performed this operation on 2 patients in 1945, and in May 1948 he reported a total of 41 patients with 6 deaths and good results in 32.[37] Blalock operated on 21 patients with 3 deaths, in 16 of whom end to end suture was accomplished and in 4 a subclavian-aortic anastomosis was done.[37e] Stephens of California reported 6 cases in 1948, with the 3 survivors well.[38] Jones reported 13 cases, in 9 of which end to end suture was utilized, and 4 with subclavian-aortic anastomosis. There were 2 deaths in his series.[39]

TETRALOGY OF FALLOT

The tetralogy of Fallot is present in the majority of cases of congenital cardiovascular defects which are accompanied with cyanosis. Prior to the brilliant contribution of Blalock and Taussig in 1943, patients suffering from this condition were faced with a hopeless outlook, only a few surviving beyond the first decade.[40] The components of the tetralogy are pulmonic stenosis, interventricular septal defects, dextroposition of the aorta and hypertrophy of the right ventricle. The chief disabling factor is pulmonic stenosis or atresia which prevents an adequate flow of blood to the lungs with resulting deficiency in oxygenation. It is in large part this factor which the Blalock operation attempts to overcome by anastomosis of one of the systemic arteries arising from the aortic arch to the right or left pulmonary artery.

35. Abbott, M. E., cited by Crafoord.[36]

36. Crafoord, C., and Nylin, G.: Congenital Coarctation and Its Surgical Treatment, J. Thoracic Surg. **14**: 347-361, 1945.

37. (*a*) Gross, R. E.: Surgical Correction for Coarctation of the Aorta, Surgery **18**: 673-678, 1945. (*b*) Gross, R. E.: Technical Considerations in Surgical Therapy for Coarctation, Surgery **20**: 1-8, 1946. (*c*) Gross, R. E., in discussion on Blalock.[37e] (*d*) Gross, R. E., and Hufnagel, C. A.: Coarctation of the Aorta, New England J. Med. **233**: 287-293, 1945. (*e*) Blalock, A., and others: The Surgical Treatment and the Physiopathology of Coarctation of the Aorta, read before the American Surgical Association, May 29, 1948.

38. Stephens, H. B., in discussion on Blalock.[37e]

39. Jones, J. C., in discussion on Blalock.[37e]

40. (*a*) Blalock, A.: Surgical Treatment of Congenital Pulmonic Stenosis, Ann. Surg. **124**: 879-887, 1946. (*b*) Blalock, A.: The Use of Shunt or Bypass Operations in the Treatment of Certain Circulatory Disorders Including Portal Hypertension and Pulmonic Stenosis, Ann. Surg. **125**: 129-141, 1947. (*c*) Blalock, A.: Surgical Treatment of Pulmonary Stenosis, Lancet **2**: 478-479, 1947. (*d*) Blalock, A., and Taussig, H.: Surgical Treatment of Malformations in Which There Is Pulmonary Stenosis or Pulmonary Atresia, J. A. M. A. **128**: 189-202 (May 19) 1945.

The important diagnostic features in this condition are cyanosis, roentgenologic evidence of decreased size of the pulmonary artery and absent or diminished pulsations together with absence of congestion in the lung fields. The most suitable age for operation is from 2 to 10 years; it is not advised in infants 18 months or younger.

Although each of the vessels arising from the aortic arch have been utilized for anastomosis Blalock prefers the innominate subclavian, because of the better angle it makes when swung down to the pulmonary. The end of the systemic artery is best anastomosed to the side of the pulmonary artery, since in this way the new blood flow can reach both lungs, a condition which would not obtain in an end to end suture.

In Blalock's last published report 243 patients had been operated on, with a 21 per cent mortality rate and only a 15 per cent mortality rate in the last 100 patients.[40b] In a paper read before the Royal Society of Surgeons in London in September 1947, he cited 474 cases with an over-all mortality rate of 18 per cent.[40c] Stephens reported twenty-two anastomoses, with a 4.5 per cent mortality rate.[41] Dodrill reported 12 cases, with 3 deaths and 5 cases with excellent results.[42] Murray in Canada has operated on 94 patients.[43] In my clinic only 5 patients have been operated on.

In general the results in the patients surviving operation have been phenomenal, and it has been remarkable how well the pathetic, weak and cyanosed children have tolerated the operation. There has been little or no difficulty with the arm after sacrifice of the subclavian artery. It may be said that the operation represents an outstanding contribution to surgery, has proved thus far to be effective and has given hope to hundreds of patients formerly doomed to death or early invalidism.

About a year and a half after Blalock and Taussig's first publication Potts, Smith and Gibson reported an ingenious operation for this condition, consisting of a side to side anastomosis between the aorta and the right or left pulmonary artery.[44] This anastomosis was made possible by a specially devised clamp, which pinches off and occludes a portion of the aorta for suture but leaves a channel through which blood can continue to flow. The advantages of this operation are that the size of the artificially created communication can be varied to suit the needs of the patient and that it is well suited for use in patients in whom, because of the anatomy of the vessels, there is difficulty in making the systemic artery reach the pulmonary. No reports of the operation other than those by its originators have appeared. In a second paper they reported forty-five completed operations with 4 deaths (8.8 per cent) and seven explorations with 3 deaths.

AORTIC RING

The majority of anomalies of the aortic arch, exclusive of patent ductus arteriosus, give rise to few symptoms and have received little attention from a surgical point of view. Recently several of these abnormalities have been recognized as factors capable of producing troublesome and sometimes fatal compression of the trachea or esophagus. In 1945 Gross emphasized the importance of such anomalies and was the first to treat them successfully by surgical means.[46] The conditions to which he has directed particular attention are: (1) right aortic arch in which the aorta passes behind the esophagus, with variable arrangements of the vessels arising from the arch which, often in conjunction with a patent ductus arteriosus or a ligamentum arteriosum, cause compression of the encircled trachea or esophagus, and (2) double aortic arch in which the ascending aorta splits in two limbs encompassing the trachea and esophagus and joining beyond to form the descending aorta. The posterior limb passes behind the esophagus and the anterior one in front of the trachea.

Whether symptoms develop as a result of such anomalies depends on the size of the space between the encircling vessels in relation to the size of the encircled trachea or esophagus. The symptoms appear soon after birth, are referable to the compressed viscera and consist of dysphagia, wheezing respiration, stridor, retraction of the chest and cough, all of which are increased during the act of swallowing. Frequent bouts of bronchitis or pneumonia result from aspiration into the bronchial tree of material spilled over during attempts to swallow. The diagnosis is readily made by roentgenologic means, whereby indentations can be seen in the esophagus after ingestion of barium sulfate, and narrowing of the trachea is visualized after instillation of iodized oil.

The operation consists in relieving the constricting ring by dividing it at appropriate points. This may entail (1) division of the anterior limb of a double aorta at a safe site, (2) division of a patent ductus or ligamentum arteriosum or (3) a combination of the two procedures. Gross obtained cures in 2 patients using these methods. These are the first and only surgically treated patients that have been reported. With the recent emphasis placed on it, this condition should be more frequently recognized and more adequately treated.

CONCLUSION

In conclusion I should like to emphasize the following points:

1. Surgery of the heart and associated great vessels has made remarkable strides in the past few years.

2. The rapidly growing interest in this type of surgery is sure to result in further advances. The recent attempts at surgical attack on certain types of valvular disease by Smithy [47] and by Gibbon [48] and the efforts at closure of interauricular septal defects reported by Gordon Murray [49] are evidence of this statement.

3. It behooves the medical profession in their efforts to reduce the present ravages of heart disease to be aware of what can be accomplished by surgical treatment.

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AUREOMYCIN THERAPY OF ROCKY MOUNTAIN SPOTTED FEVER

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Aureomycin is an antibiotic derived from a strain of Streptomyces aureofaciens).[1] It has been found to protect mice and guinea pigs infected with the rickettsia of Q fever, Rocky Mountain spotted fever, murine typhus and rickettsial pox.[2] The drug is readily absorbed after oral administration. Although quantitative assay in the body fluids has not been satisfactory, low levels (0.3 to 2.5 micrograms per millimeter) have been detected in the blood serum and levels up to 320 micrograms per milliliter [3] in the urine. Pharmacologic studies in animals have shown that the toxicity of the drug is low except after intravenous administration where hemoglobinuria and anemia have been noted.[4] In human beings, therapeutic doses up to 60.0 milligrams per kilogram of body weight per day given orally have not been associated with any toxic manifestations except for occasional nausea and vomiting.[5] The latter has been transient and does not contraindicate or prevent continuation of therapy. In the present series the antibiotic was found to be free of any untoward reactions.

In view of the experimental evidence that aureomycin possessed antirickettsial activity, and the absence of toxicity of the drug when given orally, it was decided to treat patients suffering from Rocky Mountain spotted fever, Eastern type, with this antibiotic. Thirteen patients with Rocky Mountain spotted fever, diagnosed clinically and confirmed serologically, have been treated since June 1948.

The response of these patients has been impressive, and it is apparent that aureomycin is an effective therapeutic agent. Seven patients were treated at the Children's Hospital, Washington, D. C. One patient was treated at each of the following hospitals: Georgetown Hospital, Washington, D. C.; Providence Hospital, Washington, D. C.; Arlington General Hospital, Arlington, Va.; Prince George General Hospital, Cheverly, Md.; Sydenham Hospital, Baltimore, and Union Memorial Hospital, Baltimore. Several patients whose disease was diagnosed clinically but as yet unconfirmed serologically are not included in this series. The course of these patients, after treatment with aureomycin, paralleled that noted in the cases presented.

The significant observations in this series of patients are tabulated in table 1 and summarized in table 2. In the latter, data obtained from observation of untreated patients and those treated with para-aminobenzoic acid are included for comparison.

The two case histories presented serve to illustrate the general course of the disease as observed in this series of patients treated with aureomycin.

REPORT OF CASES

CASE 1.—J. K., an 8 year old white boy, was admitted to Children's Hospital on June 25, 1948, with the complaint of fever of two days' duration and a rash of one day's duration. Ten days prior to entry, an embedded tick was removed from the boy's scalp. The child was well until two days before admission, at which time a temperature elevation to 103 F. was observed. On the following day, the temperature fluctuated between 103 and 104 F., and during the afternoon a rash appeared on the arms, legs and chest. Past history and family history were noncontributory.

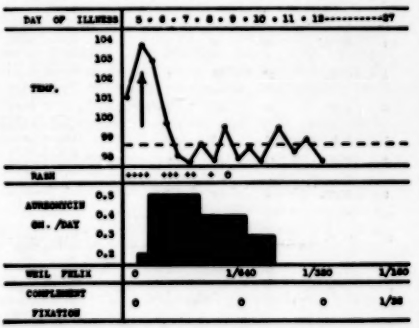

Chart of treatment with aureomycin and observations in a case of Rocky Mountain spotted fever (case 9, W. K., age 3, weight 30 pounds [13.6 Kg.]).

The child was obese and moderately apprehensive, but not critically ill. His temperature was 104 F. A red maculopapular rash which blanched on pressure was observed on his entire body, including the palms and soles. Otherwise the results of his physical examination were negative.

The laboratory examinations showed a hemoglobin level of 13 Gm., 3,900,000 red cells and a white cell count of 6,900, with 63 per cent neutrophils, 34 per cent lymphocytes and 3 per cent monocytes. The results of urinalysis were negative. Subsequent daily blood cell counts and urinalyses during therapy showed no essential variation from the normal. Results of other tests of the chemical content of the blood were normal. Results of cephalin flocculation tests, both on entry and three days later, were negative. On admission, results of a Weil-Felix agglutination test with Proteus OX_{19} and a complement fixation test for Rocky Mountain spotted fever were negative. Seven days later, the Weil-Felix reaction was positive in a titer of 1:160 and the reaction to the complement fixation test performed at the National Institute of Health was positive in a titer of 1:64.

Aureomycin therapy was started within two hours after admission. Initially the patient received 50 mg. every hour

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Aureomycin ("duomycin") was supplied by the Lederle Laboratories Division, American Cyanamid Company.

From the Research Foundation of Children's Hospital, Washington, D. C., and the Department of Preventive Medicine, the Johns Hopkins University School of Medicine.

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3. (a) Dornbush, A. C.: The Determination of Aureomycin in Serum and Other Body Fluids, in Conference on Aureomycin—A New Antibiotic, New York Academy of Science, Section on Biology, July 21, 1948. (b) Schoenbach, E. B.; Bryer, M. S., and Long, P. H.: Pharmacological and Clinical Studies with Aureomycin, in Conference on Aureomycin—A New Antibiotic, ibid. 1948.

4. (a) Cunningham, R. W.: Pharmacology of Aureomycin, in Conference on Aureomycin—A New Antibiotic, New York Academy of Science, Section of Biology, July 21, 1948. (b) Bryer, M. S., and Schoenbach, E. B.: Treatment of Experimental Infections with Aureomycin, in Conference on Aureomycin—A New Antibiotic, ibid. 1948.

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for three doses and then 100 mg. every four hours. The drug was well tolerated, and no nausea or vomiting was encountered. Within three days after initiation of therapy with aureomycin, the temperature had returned to normal and remained so during the rest of the boy's hospital stay. The rash became petechial and then gradually faded. It had disappeared entirely by the seventh day of his disease and the fourth day of treatment. Aureomycin therapy was discontinued on July 1, after an uneventful convalescence.

CASE 9 (table 1).—W. B., a 3 year old white boy, was admitted to the Union Memorial Hospital, Baltimore, on July 19, 1948, on the service of Dr. T. E. Daniels and Dr. Young, with the complaint of fever for five days and a rash of four days' duration. Nine days prior to entry, an embedded tick was removed from the boy's scalp. The child was well until five days before admission, at which time fever was observed. On the following day, the fever continued and a rash appeared on the arms and legs. It spread rapidly to involve the face and trunk. Past history and family history were noncontributory.

The child was well developed and well nourished. He appeared acutely ill and slightly lethargic. His temperature was 103 F. An erythematous maculopapular petechial rash was present on his head, trunk and extremities, including his palms and soles. There was moderate generalized adenopathy. His spleen tip was palpable 2 fingerbreadths below the left costal margin. Slight nuchal rigidity, with positive Kernig and Brudzinski signs, was present. Otherwise the results of the physical examination were negative.

The laboratory examination of the blood showed a hemoglobin of 11.0 Gm.; the white cell count was 12,250, with 73 per cent neutrophils, 24 per cent lymphocytes and 3 per cent monocytes. Repeated urinalyses were normal. The nonprotein nitrogen in the blood was 24 mg. per hundred cubic centimeters, and the total protein was 6.4 Gm. per hundred cubic centimeters. The reaction to the cephalin flocculation test was negative. On admission, a Weil-Felix agglutination test with Proteus OX_2 and OX_{19} and a complement fixation test for Rocky Mountain spotted fever performed by Dr. Herald Cox showed negative reactions. Four days later, the result of the Weil-Felix (OX_{19}) test was positive in a dilution of 1:640. The reaction to the complement fixation test was still negative. Three weeks later, the agglutination for Proteus OX_{19} was positive in a dilution of 1:160, and the complement fixation titer was 1:32.

Aureomycin was administered on the day of admission. The patient was given 50 mg. every hour for three doses. Thereafter 50 mg. of the antibiotic was given every three hours. The drug was well tolerated, and no nausea or vomiting occurred. Within two days after intiation of treatment, the temperature had returned to normal and the patient was alert and eating well. The rash disappeared by the fourth day of treatment. Aureomycin therapy was discontinued after five days, and the patient was discharged from the hospital as cured on the seventh day after treatment was begun. When seen three weeks later, the patient was well. The clinical course of this patient is illustrated in the chart.

TABLE 1.—*Summary of 13 Patients with Rocky Mountain Spotted Fever Treated with Aureomycin*

Case No.	Patient	Age, Yr.	Weight Kg.	Day of Disease Aureomycin Begun	Days of Fever After Aureomycin Started	Aureomycin Dose, Mg./Interval, Hr., Period or Doses	Aureomycin per Dose, Mg./Kg.	Duration After Aureomycin Was Begun, Days	Total Aureomycin, Gm.	Results of Tests: Weil-Felix	Results of Tests: Complement Fixation *	Severity †	Outcome
1	J. K.	8	56	2	3	50/1/3 doses 100/4/5 days	2	5½	3.3	1:160	1:64	2+	Recovered
2	M. N.	1½	9	8	1½	100/1/3 doses 100/2/7 days	11	7	8.2	1:320	Negative	4+	Recovered
3	B. A. H.	5	17	2	3	200/2/4 days 100/4/2 days	12	6	9.7	1:2560	1:32	2+	Recovered
4	M. M.	10	40	3	2	200/1/3 doses 200/2/1½ days 200/4/2½ days	5	7	12.4	1:640	1:32	2+	Recovered
5	G. P.	10	30	8	3	200/1/3 doses 200/2/6 days 100/4/3 days	7	9	16.3	1:2560	1:64	3+	Recovered
6	J. M.	13	30	4	2	200/1/3 doses 200/2/3½ days 200/4/1½ days	3	5½	11.3	1:1280	1:64	2+	Recovered
7	J. R.	7	25	6	2	100/1/3 doses 100/2/5 days	4	5	5.4	1:320	Not done	3+	Recovered
8	F. S.	14	45	5	2	100/1/2 doses 100/4/1 day 100/2/5 days	2	6	6.2	1:1280	1:16	3+	Recovered
9	W. B.	3	14	5	2	50/1/3 doses 50/3/5 days	4	5	2.3	1:640	1:32	3+	Recovered
10	M. O.	4	19	3	2½	100/1/3 doses 100/2/4 days	5	4½	5.2	1:320	1:32	3+	Recovered
11	G. B.	50	70	4	2	200/1/3 doses 200/2/3 days 200/4/3 days	3	7	10.0	1:640	1:64	3+	Recovered
12	P. J.	15	64	2	2	200/1/3 doses 200/3/3 days	3	5½	5.4	.....	1:32	2+	Recovered
13	D. P.	6	24	4	2	200/1/4 doses 200/4/3¼ days 200/6/2 days	8	6	6.0	1:160	....	2+	Recovered

* Rocky Mountain spotted fever antigen.
† 2+ equals moderately toxic fever, temperature of 104 F. or above, with generalized rash; 3+ equals severely toxic fever, with petechial eruption, and 4+ equals coma, convulsions or edema.

COMMENT

It was considered advisable to give three initial "loading" doses of 2 to 5 mg. of aureomycin per kilogram of body weight at hourly intervals and then the same dose every two hours thereafter as maintenance therapy. The dosage schedule was usually changed to four hour intervals after the temperature had been normal for approximately forty-eight hours. In this series aureomycin was administered for a mean period of six days; the shortest period of therapy was four and one-half days, while the longest was nine days. No exacerbations of fever were noted in any case after cessation of treatment with the drug. There seemed to be no definite correlation between the total amount of the drug given and the duration of fever after initiation of therapy. Thus in cases 1 and 8 (table 1) 2 mg. of aureomycin per kilogram of body weight per dose was administered, and the temperature became normal within approximately the same period of time (i. e., two days) as in cases 2 and 3 in which 11 and 12 mg. per kilogram of body weight per dose were given. The total amount of aureomycin administered in our series

ranged from 2.3 to 16.3 Gm., with an average of 9.5 Gm. per patient.

The optimal dose of aureomycin in spotted fever has not been determined in this study, and further investigation will be required to define the dosage range within which salutary results may be expected. However, it would appear that an excellent clinical response may be expected when daily doses of 30 to 60 mg. of aureomycin per kilogram of body weight are given orally in this disease. The intramuscular or intravenous routes of administration of aureomycin were not used in these patients.

Definite toxic manifestations were not noted. Some nausea and vomiting was encountered in 4 cases during the first two days of treatment. In 2 of the patients, the simultaneous administration of aluminum hydroxide tablets seemed to mitigate these symptoms. It was difficult to dissociate the nausea and vomiting often encountered in spotted fever from that which might have been attributed to aureomycin. The older children in the group were able to swallow the capsules of aureomycin (50 or 100 mg. per capsule) without too

TABLE 2.—*Summary of Results in Patients with Spotted Fever Who Received No Specific Therapy and Those Who Received Para-Aminobenzoic Acid or Aureomycin*

	Non-specific Therapy, 1932-1945	Specific Therapy: 1946-1947, Para-Amino-benzoic Acid	Specific Therapy: 1948, Aureo-mycin
Number of cases	30	17	13
Average number of days after onset when treatment was begun	..	6.5	4.5
Average number of days of fever after treatment was begun	..	6.3	2.3
Average number of days of fever	18	12.8	6.8
Average number of days of rash	12	6*	4*
Average number of days in hospital	20	12	8
Incidence of complications (including pneumonia, myocarditis and parotitis), percentage	26.6	17.6	0
Deaths, percentage	10	0	0

* It is to be noted that the duration of the rash in both the patients treated with para-aminobenzoic acid and those treated with aureomycin represents the post-treatment interval.

much attendant difficulty. In the younger children it was given as a solution in tap water or incorporated in a syrup. No vomiting of the drug was encountered after the second day of treatment.

The rash usually disappeared within three to five days after the initiation of drug therapy in the patients who were treated early (i. e., within two to four days after onset of the disease), and in these patients the rash did not become petechial. However, in cases 2 and 5, in which the drug was started on the eighth day of the disease, the rash was slow to fade and the petechial manifestations of the rash were still present after one week.

The rapid defervescence observed in all patients treated with aureomycin was matched by the striking clinical improvement. The majority of patients on admission to the hospital were toxic, irritable, anorexic and lethargic. However, within twenty-four to forty-eight hours after starting aureomycin therapy, the children were much more active and alert and showed a return of appetite and interest in their surroundings.

Adjuvant therapy, such as isotonic sodium chloride solutions, plasma and blood, which had been found to be important in the management of spotted fever in past years, was used in only 2 cases (cases 2 and 5); in both instances the disease was in its eighth day before treatment with the drug was started, and both children were in need of supportive therapy. In the other 11 cases, however, the response to aureomycin was so rapid and the course of the disease so promptly altered that no supportive treatment was required, since the children took adequate food and drink within twenty-four to forty-eight hours after the antibiotic therapy was started.

COMPARISON WITH PREVIOUS METHODS OF MANAGEMENT OF SPOTTED FEVER

In view of the endemic concentration of Dermacentor variabilis in the Maryland and Virginia areas, we have had a good opportunity to study spotted fever since its identification in the East in 1931 by Badger, Dyer and Rumreich.[6] In the seventeen years up to and including 1947, there have been 47 patients admitted to Children's Hospital. These patients have been described in previous reports.[7]

From 1932 to 1945, prior to the advent of para-aminobenzoic acid (PABA), 30 cases were observed. The patients were treated only with supportive and symptomatic therapy. Complications were frequent, and the mortality rate in this group was 10 per cent. The average duration of fever in these cases was eighteen days, while the rash persisted for twelve days, usually becoming petechial after the first week. The average hospital stay was twenty days, while the incidence of complications (including pneumonia, myocarditis and parotitis) was 26.6 per cent.

During the summers of 1946 and 1947, there were 17 patients with spotted fever, all of whom were treated with para-aminobenzoic acid. There were no deaths in this group. The average duration of temperature following treatment with para-aminobenzoic acid was six days, and the rash generally persisted for an equal period of time (i. e., six days). The usual duration of hospital stay was twelve days, while complications were observed in 17.6 per cent of the patients. This represented a distinct improvement over that previously encountered in the group who received no specific therapy.

In the present series of patients treated with aureomycin during the summer of 1948 there were 13 patients. Aureomycin was found to be superior to para-aminobenzoic acid for several reasons. First, the temperature response was much more dramatic. In all 13 cases a rapid defervescence to normal by crisis was noted; the average duration of fever after initiation of treatment with the drug was two and one-third days. It was significant that even in the 2 patients with spotted fever who were not treated with aureomycin until the eighth day of their illness (cases 2 and 5) there was an equally dramatic drop in temperature within thirty-six and seventy-two hours, respectively, and a concomitant improvement clinically. This is to be contrasted with previous experience with para-aminobenzoic acid, where, in 7 patients treated after the seventh day of illness, the average duration of fever following institution of therapy was ten days. Of the 3 patients who were severely ill and in whom complicating pneumonitis developed in the series in which para-aminobenzoic acid was used, 2 were started on para-aminobenzoic acid

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therapy on the eighth day, while the third received the first dose on the sixteenth day. There appears to be little doubt, both from the reports of others [8] and from our own observations,[7c] that favorable therapeutic results were not obtained with para-aminobenzoic acid unless treatment was started before the seventh day of the disease. In the treatment of advanced disease, it would appear, from these preliminary studies, that aureomycin is preferable to para-aminobenzoic acid because of the rapidity of the therapeutic response to this antibiotic. The duration of the rash in the group treated with aureomycin was shorter than in the series treated with para-aminobenzoic acid, averaging four days. Therapy with aureomycin cured the patients and permitted them to be discharged from the hospital more expeditiously, the average stay in the hospital being eight days. Some of the patients were retained in the hospital for a longer period of time than was considered necessary from the point of view of treatment in order to obtain serologic confirmation of the diagnosis. There were no complications in the patients treated with aureomycin.

A comparison between the toxicity of para-aminobenzoic acid and aureomycin should be of interest because any drug destined for widespread usefulness must not be too toxic. In previous reports on the use of para-aminobenzoic acid in spotted fever [7b,c] it was noted that this drug would produce leukopenia in a certain number of cases, and when this occurred the drug had to be discontinued. In addition, many of the patients receiving para-aminobenzoic acid showed a 3 plus and 4 plus cephalin flocculation reaction and a significant drop in the prothrombin level. These observations indicate that there is the possibility that para-aminobenzoic acid exerts an untoward effect on hepatic function. Damage of the liver and kidneys has been observed in postmortem examination of several children treated with para-aminobenzoic acid in diseases other than spotted fever.[9] In addition to daily white cell counts and frequent tests of hepatic function, it was necessary, in following a patient treated with para-aminobenzoic acid, to perform daily tests of para-aminobenzoic acid levels, as well as levels of blood nonprotein nitrogen and carbon dioxide at frequent intervals.

Aureomycin to date appears to be relatively nontoxic when administered orally. No evidence of toxic manifestations other than slight nausea and vomiting was encountered either in the patients with spotted fever or in a control group of normal children. In this latter group, which will be reported more fully elsewhere, a series of laboratory studies (including blood studies, urinalyses, blood nonprotein nitrogen determinations, carbon dioxide–combining power, cephalin flocculation, prothrombin levels, total proteins, Van den Bergh, blood sugar, platelet and reticulocyte counts, bleeding and clotting times and fragility tests) were performed at regular intervals while the subjects were receiving aureomycin in therapeutic doses. No significant changes were encountered in any of these children during the seven days that the drug was given. It is possible, however, that toxic manifestations might yet be noted after a much larger series of patients treated with this drug has been observed. Although no allergic reactions have been encountered so far in our experience, this does not rule out the possibility that such reactions may occur.

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CONCLUSIONS

Aureomycin, a new antibiotic, was used in the treatment in 13 cases of Rocky Mountain spotted fever during the summer of 1948. The temperature subsided rapidly, within an average period of two and one-third days, and striking clinical improvement was observed in all of the patients. No toxic effects from the drug were noted. Comparison with para-aminobenzoic acid would indicate that aureomycin is a more effective agent in the treatment of spotted fever.

THE USE AND ABUSE OF ESTROGEN

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Our knowledge of the physiology of the ovary has passed beyond the original concept of a simple endocrine gland which might possibly produce symptoms by means of quantitative variations of its secretions. The advances of the last two decades have made available clinically useful preparations of the two hormones of the ovary, estrogen and progestogen. This paper deals with estrogen—the hormone of growth and preparation—the more widely employed of the two.

When estrogen first became available for clinical use, there was an understandable overenthusiasm for its application. The rational indications, however, of estrogen usage have contracted measurably following earlier empiric trials. Nevertheless, there is still much confusion concerning estrogenic dosage and the avoidance of undesirable side actions. If one depends on the beautifully embossed brochures which exhort the practitioner with every mail, one falls, unhappily, into the security of the illusion that there are neither contraindications nor side effects in the use of estrogen. Such pamphlets, while providing succinct clinical reviews and emphasizing the multiple commercial forms of estrogen, are often full of omissions.

PREREQUISITES OF ESTROGEN THERAPY

It seems expedient to reemphasize four basic maxims, the observance of which is prerequisite to the administration of estrogen.

1. *Preliminary Physical Examination.*—Prior to prescribing estrogen, a complete survey of the patient must be made to exclude the presence of any organic gynecologic or constitutional disorder which would preclude its use. The ordinary diagnostic procedures, including complete physical examination, blood count, urinalysis, serologic study, biologic tests for pregnancy and determination of the basal metabolic rate, should be employed as indicated.

2. *Consideration of Menstrual Physiology.*—Inasmuch as estrogen is a potent force in the regulation of menstruation, knowledge of the patient's menstrual cycle is of paramount importance. Despite the fact that most physicians have some understanding of the current concept of menstrual physiology, and at the

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risk of being somewhat pedantic, a brief review of its cardinal features is presented.

The cyclic ovarian changes are governed by the follicle-stimulating, luteinizing and luteotrophic hormones of the anterior lobe of the hypophysis. These are responsible for maturation of the follicle, ovulation, luteinization and maintenance of the corpus luteum. The recurring changes in the endometrium are, in turn, dependent on the hormones estrogen and progestin, secreted respectively by the ovarian follicles and the corpus luteum.

At the conclusion of the menstrual flow, resulting from the presence of estrogen, the endometrium changes from a thin layer of cells practically devoid of glands to a tall, richly glandular tissue. Throughout this phase, the cells of the endometrial glands are filled with the growth-associated enzyme, alkaline phosphatase.[1] After the ripening of one follicle, ovulation occurs during the midportion of the cycle. The empty follicle collapses and is transformed within a few days into a corpus luteum. The luteotrophic gonadotrophin supports the continued function of the corpus luteum, stimulating the production of both estrogen and progestin for a limited time.

During the second half of the cycle, progestin causes the estrogen-primed endometrium to become a hyperemic, highly functional tissue. The cells of the endometrial glands are, at this time, richly endowed with the nutritive substances which are necessary for the embedment and support of a fertilized ovum. If fertilization does not occur, the corpus luteum disintegrates because of failure to receive the support of trophoblastic luteotrophin. Almost immediately thereafter, the endometrium, so earnestly constructed to house a pregnancy, suffers from the withdrawal of the corpus luteum hormones and is dismantled by the process of menstruation.

3. *Evaluation of Pharmacologic Principles.*—The ovarian hormones, estrogen and progestin, belong to the steroid family of hormones, a group which also includes androgens and the adrenocortical hormones. The ovarian steroids have been chemically identified, their structural formulas are known, they are available in pure crystalline forms and have been made synthetically. They are stable and will remain potent indefinitely without refrigeration. Inasmuch as they contain no protein, neither of them per se gives rise to allergic manifestations, but they are frequently dispensed in vegetable oils which have been known to evoke sensitization. They may be administered intramuscularly, orally and by absorption through skin or mucous membrane. They have the significant dual ability of acting both on the genital end organs and on the anterior lobe of the hypophysis. The latter propensity, especially true of estrogen, has bearing in its use in the regularly menstruating woman because it may disturb the rhythm of her cycle by depressing the production of hypophysial gonadotrophins.

4. *Selection of Patients.*—Of equal importance with the previously stated maxims is the realization that no 2 patients ever present the same endocrinologic problem. The value of such individualization is clearly emphasized by the varied treatment accorded the same endocrinopathy at different ages. Moreover, not only must treatment be directed to the disorder in question, but it must also be so administered that associated derangements are aided. Whenever necessary, advice relevant to better living habits and to the solution of unsolved social problems should be proffered. Finally, adjuvant medication, such as iron, and dietotherapy should not be overlooked.

USES OF ESTROGEN

The physiologic effects of estrogen make it clinically useful in three broad categories—to achieve growth of all or part of the genital tract, to depress temporarily the function of the anterior lobe of the hypophysis and to effect an antiandrogenic action. In the first instance are included the treatment of atrophic vaginitis and the adjunctive therapy of amenorrhea; in the second, the suppression of lactation and the alleviation of the menopausal syndrome, and, in the third group, the temporary resolution of the metastatic lesions of prostatic carcinoma and the restraint of postoperative erections following penile plastic operations.[2]

Atrophic Vaginitis.—Postmenopausal vaginitis occurs because of the extreme vulnerability of the atrophic vaginal mucosa to trauma and infection. The cessation of ovarian function, depriving the vagina of the trophic effect of estrogen, results in diminution of the layers of the epithelium, disappearance of the glycogen content of the cells and loss of the protective vaginal flora. Deprived of these natural barriers to infection, the vagina becomes fertile soil for bacterial growth. The atrophy and subsequent infection give rise to the symptoms of irritating leukorrhea, introital paresthesia and dyspareunia. Trichomonas vaginalis is often a secondary invader under such circumstances.

Since the absence of estrogen is the basic cause of this disorder, it is logical to administer estrogen to restore the vaginal epithelium to its former height and state of resistance. The dosage of estrogen employed for this purpose should be small, inasmuch as the vagina responds to very small quantities. It may be given effectively orally as either 0.5 mg. of diethylstilbestrol or 0.625 mg. of estrone sulfate daily for several weeks. Given intravaginally, smaller quantities of estrogen may be employed. The nightly introduction of a vaginal suppository containing 0.2 mg. of estrone is satisfactory, but many patients object to it because of nocturnal soiling. However prescribed, the estrogen should be discontinued within a month and repeated only if required for a recrudescence of symptoms.

Secondary Amenorrhea.—The causes of secondary amenorrhea are so protean that intelligent therapy cannot be applied without a complete investigation of the constitutional background of each amenorrheal woman. The treatment of amenorrhea with estrogen alone is notoriously unsatisfactory. Estrogen evokes only the proliferative phase of endometrial growth. Although uterine bleeding may result from such growth, it is not menstruation.

The objective of estrogen therapy in amenorrhea is the cure of uterine hypoplasia. If such atrophy—perhaps the sequel of a previously existing pituitary-ovarian deficiency—is the sole cause of the amenorrhea, fair results may be obtained from treatment with estrogen. In such women, the endometrium is rebuilt to a point of normal responsiveness, and, in effect, the estrogen acts merely as the "starter" which sets the abeyant cycle in motion. Unfortunately, this applies to few amenorrheal women.

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An effective technic of employing estrogen in the treatment of amenorrhea is its administration with the corpus luteum hormone, progestin. They may be given either together, as a combined injection, or separately in consecutive manner. In the former method, the amenorrheal patient may be given a combined intramuscular injection of 2.5 mg. of estradiol benzoate and 12.5 mg. of progesterone on two successive days. Using the consecutive style, one may administer 1.5 mg. of estradiol benzoate intramuscularly every third day for five doses and follow immediately with five daily injections of 10 mg. of progesterone. Such dual therapy, combined or cyclic, is generally repeated for three consecutive months.

When parenteral medication is to be avoided, estrogen and progestin may be administered orally. A suitable schedule, for example, is the use of 2 mg. of diethylstilbestrol daily for fifteen days, followed by 60 mg. of pregneninolone, the "oral progestin," daily for five days.

It must be remembered that neither estrogen alone nor estrogen with progestin gives permanent results in amenorrhea unless other measures are taken simultaneously to restore the general health of the patient.

Puerperal Engorgement of the Breasts.—One of the most satisfactory uses of estrogen is the prevention of breast engorgement when postpartum inhibition of lactation is desired. If the administration of estrogen is started immediately after delivery, there is generally entire freedom from pain and engorgement, as well as distinct depression of lactation. In fact, when suckling is not permitted, lactation, in the clinical sense, rarely occurs. If the administration of estrogen is started after lactation has been established, relief from engorgement and subsidence of lactation are hastened.

The dosage of estrogen required to prevent puerperal breast engorgement is relatively small. Intramuscular administration for this purpose is not required. As little as 1 mg. of diethylstilbestrol, or its equivalent in natural estrogen (such as 1.25 mg. of estrone sulfate), given orally three times daily for a week is adequate. The estrogen is then best withdrawn gradually by a reduction of one dose daily for several days.

The danger of administering estrogen during the puerperium is its propensity to create hyperplasia of the regenerating endometrium, which may result in abnormal bleeding. This unwanted effect may be avoided by employing only small doses of estrogen for a limited period and by discontinuing its use gradually.

Menopausal Syndrome.—Most women do not require treatment for the menopausal syndrome. In this majority group, the flushes, nocturnal sweats and nervous instability are mild and may be completely mitigated by consultation alone. An explanation of the temporary nature of the symptoms and of their tendency to disappear spontaneously after a variable time, coupled with the sympathetic prescription of a mild sedative, may be all that the patient requires. However, when the symptoms are troublesome, there is no more specific therapy than estrogen.

The orally administered estrogens are ideal for menopausal therapy; there is virtually no need for parenteral administration. The smallest oral dose required to assuage the vasomotor symptoms should be prescribed. Whether one employs a daily dose of 0.5 mg. of diethylstilbestrol, 0.625 mg. of estrone sulfate or 0.02 mg. of ethinyl estradiol is immaterial. The important rules are to prescribe the estrogen for a limited period and to withdraw it in a gradual manner. The most prevalent abuse in the usage of estrogen is the prescription of a routine daily dose to be taken more or less indefinitely. This often results, even in women in whom menstruation has long since ceased, in the occurrence of uterine bleeding. Such bleeding also frequently follows sudden withdrawal of the estrogen. It must be emphasized that the objective of estrogen therapy of the menopausal syndrome is to aid the patient's adjustment to the diminution and cessation of ovarian function. This logical aim is lost if the estrogen is not prescribed for measured periods, with repeated attempts to withdraw the hormone entirely. When the latter is accomplished gradually, withdrawal bleeding is generally avoided.

Postmenopausal uterine bleeding evoked by estrogen is most often caused by faulty dosage and incorrect method of withdrawal. It does, however, also occur in some of the properly controlled patients, in whom the endometrium is peculiarly sensitive to estrogen.

The unfortunate faculty of estrogen of inducing uterine bleeding in the postmenopausal woman is indirectly responsible for many instances of neglected carcinoma of the uterus. Prior to the almost universal use of estrogen for the relief of the menopausal syndrome, postmenopausal metrorrhagia was most frequently the result of uterine carcinoma. However, the current prevalence of estrogen usage has altered the incidence. The physician, faced with postmenopausal bleeding, may unfortunately lapse into a false state of security, tending—without proper examination of the patient—to attribute the bleeding to previously administered estrogen. The natural and proper suspicion in all cases of postmenopausal uterine bleeding should be carcinoma of the uterus, and the attending physician should be impelled to inspect the cervix (executing a biopsy if indicated) and to perform diagnostic curettage. That these admonitions are not universally borne in mind is well illustrated by the recorded experience of many cancer clinics. In support of this, we are privileged to cite statistics from the files of the Philadelphia Committee for the Study of Pelvic Cancer, a commission devoted to study of the histories of patients with pelvic cancer in order to analyze the factors which delay diagnosis. From December 1945 to December 1946, this committee uncovered 116 instances of unwarranted delay in the diagnosis of pelvic cancer. Of these 116 instances, 78 were classified as "physician delay" and the remaining 38 as "physician and patient delay." More significant, perhaps, is the disturbing fact that 31 of the 116 patients were given medication, oral or hypodermic, in the presence of symptoms suggestive of uterine cancer, without examination. Such a practice, particularly if the patient presents abnormal uterine bleeding, is reprehensible and criminally negligent. That such neglect may stem directly from indiscriminate prescription of estrogen is illustrated by the following 2 case histories selected at random from the 116 mentioned:

Case 1.—G. N., a white woman aged 41, had prolonged, scanty menstrual flow and menopausal vasomotor symptoms in January 1946. During February she bled intermittently for two weeks. She was advised by a physician in March—without benefit of pelvic examination—that she was "changing" and that she required "needles." The latter were given twice weekly for two months with relief of the vasomotor symptoms but not of the metrorrhagia. At that time, May 1946, the patient visited another physician who removed "a small growth

from the mouth of the womb" and advised additional "injections." These were administered weekly until the end of June, when the patient experienced a sudden vaginal hemorrhage. The final diagnosis was squamous cell carcinoma of the cervix, stage III.

CASE 2.—A. W., a Negro woman aged 50, had a sudden episode of menorrhagia and summoned a physician who did not examine her but prescribed tablets "for the change of life." Menorrhagia was repeated the next month and was followed by intermittent metrorrhagia. Noting no relief after taking the medication for two months, the patient saw a second physician who examined her and recommended admission to a hospital. The diagnosis was squamous cell carcinoma of the cervix, stage III.

These histories are shocking examples of the glaring omission of pelvic examination and of the too facile prescription of estrogen. No further comment seems necessary to emphasize the importance of pelvic examination before prescribing estrogen. Frequently, however, mere pelvic examination is not sufficient. When a postmenopausal woman who has taken estrogen begins to bleed, one does not know whether the bleeding is estrogen evoked or caused by cancer. In this dilemma, the physician may either wait expectantly, observing the effect of the complete withdrawal of estrogen, or he may perform an immediate diagnostic curettement. If he decides to wait, it is his duty to keep the patient under close observation in order that the curettage be done promptly should the bleeding continue. If estrogen evokes bleeding in a menopausal woman, she should avoid such therapy in the future. If the patient's persisting, severe, menopausal symptoms demand treatment, one may resort to testosterone propionate at a parenteral dosage of less than 300 mg. monthly—a quantity which ordinarily does not induce virilization.

Estrogen should never be administered in anticipation of menopausal symptoms. Its allegedly prophylactic use, advocated for the prevention of symptoms which may follow surgical castration, seems to be highly illogical and unnecessary. As stated previously, many women who suffer a loss of ovarian function experience no symptoms and require no therapy. In others who do, temporary estrogen therapy should be governed solely by the severity of complaints.

Prostatic Carcinoma.—The endocrine theories of Huggins [3] regarding advanced prostatic cancer have led to the recent use of estrogen in its management. Carcinoma of the prostate is often stimulated to growth by androgen. Conversely, in many patients, the inactivation or diminution of circulating androgen results in temporary regression of the cancer. This is true of malignant cells in the prostate gland and in the metastatic lesions. A decrease of circulating androgen may be accomplished by either castration or the administration of estrogen. Although castration does terminate the production of androgen of testicular origin, it does not affect the adrenal secretion of the hormone. In fact, castration may, by stimulating the functional activity of the anterior hypophysis, result in an increased supplemental secretion of androgen by the adrenal glands. It is, therefore, contended by some that the administration of estrogen, through its pituitary-depressing action, may be more effective than castration in curtailing the production of androgen.[4] The urologists have resolved this controversy by the simple expedient of employing both castration and estrogen in the treatment of prostatic cancer. Moreover, estrogen is especially valuable in men who, despite previous castration, are suffering from metastases of prostatic cancer. In such patients, estrogen not only alleviates the symptoms of the metastases, particularly the pain of osseous lesions, but also lowers the serum acid phosphatase. The latter is a definite reflection of the regression and lessened activity of the metastatic cancer cells. It must be emphasized, however, that such treatment is not curative. The estrogen-evoked diminution of the primary growth and the recession of metastases are temporary improvements, maintained for variable periods of time.

Both the synthetic and the natural estrogens may be employed in this form of therapy. The dose is entirely empiric, but should be sufficient to obtain a clinical effect. The use of diethylstilbestrol permits the best oral dosage, an adequate quantity being 1 or 2 mg. three times daily. Estradiol benzoate or estradiol dipropionate may be administered intramuscularly, especially in initiating therapy, at a dose of 5 mg. twice weekly. The duration of the estrogen therapy must be determined by the disappearance of clinical evidence of the prostatic cancer or of its metastases and by the degree of gynecomastia, an untoward side effect of the treatment. There is, of course, no objection to repeated courses of estrogen—as long as the patient properly responds to its use.

ABUSES OF ESTROGEN

There are several prevalent abuses in the clinical application of estrogen, some of which are potentially dangerous. In addition to the thoughtlessness of failing to limit the duration of treatment with estrogen, as discussed previously, physicians often overlook certain contraindications to its use. Estrogen therapy, we believe, should be avoided in the following circumstances.

Premenopausal Menstrual Irregularity.—The current tendency to prescribe estrogen for women during the fifth decade because of indefinite "middle-age complaints," manifestations rarely of menopausal origin, should be condemned. Estrogen therapy of the menopausal syndrome is intended to alleviate the vasomotor, nervous and arthritic symptoms in a woman who has ceased to menstruate. Estrogens are ill advised in the woman approaching the menopause who has vasomotor symptoms but who also exhibits irregular menstruation. Under such circumstances, estrogen may result in even more irregular bleeding and may also prolong the climacteric adjustment. The danger of confusing estrogen-evoked bleeding with metrorrhagia of more serious origin has already been discussed.

Residual Endometriosis.—Estrogen is contraindicated in women who have castration symptoms after the removal of both ovaries because of endometriosis. It must be assumed that any patient who has undergone bilateral oophorectomy because of advanced and disseminated endometriosis still harbors foci of ectopic endometrium in the remaining pelvic tissue. Such foci are but asymptomatic, microscopic lesions following the regression of castration. It should, however, be no surprise that these receded endometrial lesions are reactivated by the administration of estrogen. The resultant symptoms depend entirely on the site of the

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4. Heckel, N. J.: Evaluation of Sex Hormones in the Treatment of Benign Prostatic Hypertrophy, Carcinoma of the Prostate, and Other Diseases of the Genito-Urinary System, J. Clin. Endocrinol. 4: 166 (April) 1944.

resurgent tissue. If, for example, the residual endometrium lies in the rectal wall, estrogen-evoked functional reactivation may result in serious intestinal hemorrhage.[5] It is best, then, to avoid estrogen entirely in any woman castrated because of endometriosis. If her castration syndrome cannot be controlled by means of sympathetic reassurances and mild sedatives, androgen therapy should be tried.

Carcinoma Background.—The impression has been created that estrogen is carcinogenic, particularly in regard to carcinoma of the breasts and uterus. This implication arose from the induction of cancer in experimental animals. In such experimentation, either cancer-susceptible strains or huge dosages of estrogen were employed. The results of such laboratory investigations are not directly applicable to man. For instance, it is impossible to administer quantities of estrogen in a human being comparable to those given to experimental animals.[6] Moreover, the clinical evidence of the alleged carcinogenic tendencies of estrogen in the human female is purely clinical and, therefore, rather indirect.[7] Nevertheless, there are so-called "cancer families," in whom a susceptibility to cancer appears to be dominant. The suspicion must be entertained that women of such families have a potentially malignant substratum. Even though it is generally agreed that estrogen per se is not carcinogenic, it cannot be denied that it is a stimulant to growth of the breasts and uterus, which are frequent sites of carcinoma in the female. There is also no doubt that estrogen will accelerate the rate of growth of an existing carcinoma of either the uterus or the breast, as well as of any metastasis derived therefrom. This is best evidenced by the salutary effect of castration following radical mastectomy for carcinoma. If there is, then, a clearcut history of multiple instances of either mammary or uterine cancer in a patient's family, it is safer not to administer estrogen to that patient. It is an obvious corollary that estrogen is also contraindicated if the patient herself is a salvaged survival type of malignant neoplasia.

Palpable Benign Tumors.—The mammary ducts and the connective tissue around them are stimulated to growth by estrogen. It should not, therefore, be administered—for any reason—to a patient who has, or who has recently had excised, a fibroadenoma of the breast.

The presence of a palpable uterine fibromyoma constitutes a contraindication to the use of estrogen. Although the quantity of estrogen required to induce growth and increased vascularity of an existing myometrial tumor is not known, it is conceivable that even minimal dosage could exert an adverse effect.

Hepatic Insufficiency.—It is well established that the integrity of the liver is important to the normal metabolic fate of the steroid hormones, including estrogen.[8] The liver, for instance, through its inactivation of circulating estrogen, plays a dominant role in determining how much biologically free, circulating estrogen is available to effect changes in estrogen-stimulated end organs, such as the mammary glands. This is well illustrated by the recently reported syndrome of gynecomastia and testicular atrophy in association with cirrhosis of the liver.[9] The gynecomastia and testicular atrophy result from the failure of the cirrhotic liver to metabolize estrogen properly, permitting the circulation of a too potent form. Although it cannot be shown that these untoward effects of improper estrogen metabolism occur in any but the most advanced instances of hepatic disease, it is conceivable that severe hepatitis may temporarily result in hepatic decompensation sufficient to cause failure of estrogen inactivation. In fact, it is asserted, on the basis of animal experimentation and some clinical data, that the steroid inactivation function of the liver is controlled by certain nutritional factors.[10] Prominent among the latter is vitamin B complex, although certain amino acids and the total protein intake are also important.[11] Although the nutritional concept has not met with universal acceptance,[12] the possibility of deficient hepatic inactivation of estrogen—albeit one requiring severe hepatic disturbance[13]—is recognized. Therefore, it seems wiser, at least until further investigation clarifies the problem, to avoid the use of estrogen in patients giving a recent history of hepatitis.

SUMMARY

Four prerequisites of the clinical use of estrogen are defined.

The currently accepted usages of estrogen in the treatment of atrophic vaginitis, amenorrhea, puerperal engorgement of the breasts, the menopausal syndrome and metastases of prostatic cancer are critically reviewed. It is observed that oral administration of estrogen is entirely satisfactory, except in certain instances of amenorrhea and in the alleviation of the pain of prostatic cancer, which respond best to parenteral therapy.

It is emphasized that estrogen should never be prescribed without a specific limitation of time. This is especially important in the menopausal patient in whom estrogen is apt to evoke diagnostic disturbing uterine bleeding, impelling uterine curettage. The importance of the latter is illustrated by the citing of 2 instances of neglected uterine carcinoma.

The specific contraindications to estrogen therapy are reaffirmed. The reasons for avoiding estrogen in women exhibiting menstrual irregularities, giving a history of endometriosis, having a family background of cancer, presenting palpable mammary or uterine tumors or suffering hepatic insufficiency are restated. The regrettable use of estrogen as an "all purpose female tonic" is condemned.

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PHYSICAL MEDICINE AND PSYCHIATRY, SOME INTERRELATIONSHIPS

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Psychiatrists have probably been interested in physical medicine longer than the practitioners of any other specialty. Even in the time of Hippocrates prolonged warm baths were recognized as of value in certain mental conditions, and as long as there have been institutions for the care of the mentally ill, which made any pretense whatever of treatment, various physical methods have been employed. Hydrotherapy is, of course, the oldest, but there was a time when the static spark and the faradic current were used as well in treatment, the modus operandi being largely psychologic. Within the last ten years the almost undue attention paid to the electroconvulsive type of psychiatric therapy has diverted a good deal of attention from the better established methods of treatment, but it certainly has emphasized the usefulness of physical medicine in the field of psychiatry.

Psychiatry and physiatry have certain things in common: both are new specialties, and both arose under conditions which occasionally savored of charlatanry, with the result that certain suspicions still linger in the minds of some segments of the public. Research in the methods of causation, prevention and treatment has been only very recently developed in either field. Today, however, both have achieved standing and general acceptance as important specialties, built on a sound foundation of investigation and scientific study. There is still need of much further knowledge, however, and need of trained personnel.

It is gratifying to the psychiatrist to see the interest displayed by the practitioners of physical medicine in the psychiatric aspects of their work. So much attention has been devoted to the effects of the various modalities on the tissues and their functions that there has been at times a tendency to overlook the psychologic effect of the methods employed. The more recent work in the field of what has come to be rather cumbersomely termed "psychosomatic medicine" has done much to bring together the thinking of the psychiatrist and the physiatrist. Psychosomatic medicine is, strangely enough, not a new term. It was used in psychiatric literature in Germany over one hundred years ago, but has recently been resuscitated and refurbished so as to give the impression that it is a new discovery. This rediscovery was greatly facilitated by the contributions of William Alanson White and Adolf Meyer, and their interpretations of the "organism-as-a-whole," the concept, that is, that what we refer to as "mind" is merely one aspect of biologic functioning, that this "mental" functioning represents the adjustment at the social level to environmental influences, past and present, internal and external. More recent physiologic researches, stimulated by Cannon and followed up by Wolff and others, have demonstrated effectively the influence which the emotions exert on physical functioning. So much attention has been paid to this aspect of psychosomatic medicine that the obverse of the picture has sometimes been overlooked, namely, the fact that the malfunctioning of the physical organism has much to do with the emotional response of the patient. In other words, the person who is physically ill is not the same person emotionally as he was when he was enjoying good physical health. The hyphen (if "psychosomatic" were written with one) should be thought of as a two way sign rather than as having one direction only.

More recently another type of treatment long used in psychiatry has been officially taken under the aegis of physical medicine, namely, occupational therapy. Occupational therapy, that is, the application of various types of occupation to the treatment of neurologic and psychiatric disorder, is a valuable adjunct to the application of physical means, such as heat, electricity and massage. Occupational therapy gives vent to the patient for his aggressions; it redirects his interest in topics outside himself and can be useful in developing skills and talents and in determining emotional and physical limitations and handicap levels. It is of value not only in the mental hospital but in the rehabilitation clinic and in dealing with many types of patients who have both physical and psychologic problems. After all, every patient who has one is likely to have the other; the interaction of the two should never be overlooked.

One hears much nowadays of psychotherapy, one of the oldest forms of treatment, but one which is only recently becoming more or less formalized. Presumably every successful physician in every era has utilized psychotherapy as a part of his armamentarium, whether he knew it or not. Psychotherapy is defined by Whitehorn as "the art of modifying a patient's attitudes in a more healthy direction by the personal influence of the therapist." Certainly the physiatrist is in an extraordinarily good position to exert this particular form of influence. In the first place, he has the authority of the physician. The patient comes to him with his complaint expecting that the physician will help him toward greater comfort and efficiency. He finds in the physician's office certain apparatuses which in this day of science make a profound impression. These apparatuses, to be sure, have known physical effects, effects concerning which more is learned daily, but effects which are nevertheless clearly demonstrable.

The fact that in addition there is a symbolic value to these impressive instruments does not in the least detract from their value, their efficiency or usefulness. The patient may, for example, be suffering from some joint, muscle or nerve disability which causes substantial physical handicap. This is a field in which the physiatrist can be of great assistance from the strictly physical point of view. He can do much for his patient as well, however, if he bears in mind that the patient is suffering at the same time from anxieties and concern over the ultimate outcome of the disability and its effect on his economic status or his physical appearance. The importance of the motivation of self recognition, of facing the facts and of encouragement in the case of physical handicaps is coming to be widely recognized. Reassurance and encouragement may, of course, be overdone, but when they are properly administered they can be extremely useful for the patient's peace of mind and happiness. The confidence of the operator, his readiness to deal with situations as they come up and his general behavior are more important than words in giving a feeling of assurance and confidence to the patient. It should be borne in mind that some patients, particularly the more dependent type, are particularly searching for assurance. This is one reason that the quack is so successful, for his chief stock in trade is

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assurance and the more ignorant he is the more positive his assurances. It is important for the well trained physiatrist not to misrepresent, not to overpraise and not to make promises which he cannot keep, but he can at the same time make it clear to the patient that he is aware of the latter's needs and that he proposes to do everything possible to meet those needs and restore the patient to a useful and happy life.

Sometimes difficulty is experienced in breaking the dependency of a patient on the physician. This is particularly true of the physiatrist because of the personal contact. Some patients derive a certain amount of erotic satisfaction from the manipulations which they undergo; others are encouraged by these manipulations to fancy themselves in an earlier state, to regress to a level of childhood in which they are fondled by the parent. These situations can develop into rather awkward complications, and they call for a good deal of psychologic understanding on the part of the physiatrist and the utmost of tact and discretion. In certain types of cases it is obvious that massage and other physical manipulations should be avoided on account of their erotic effect. This is especially true in patients with a pronounced homosexual component, for example.

The possibility that the symptoms complained of may be essentially psychogenic should never be overlooked. In an interesting study published recently by Watkins, Cobb, and others [1] it was found in a series of 45 patients who complained primarily of fatigue that about 80 per cent of them were suffering from anxiety neurosis. There is a danger in such cases that overattention to the physical complaint may serve, so to speak, to fix it by directing attention to it and make it more difficult to deal with by psychotherapy. I do not mean by this that the physiatrist should try to make a psychiatrist of himself any more than the reverse should be the case. The two specialties are complementary; indeed, psychiatry is to some extent complementary to all the other specialties in the sense that no specialist can afford in justice to his patient or to himself to overlook the psychologic factors in disease. This does not mean that the psychologic factors may be dealt with only by the psychiatrist. Even if the patient could be induced to consult a psychiatrist, as often he cannot, there are not enough psychiatrists to take care even of the urgent cases. If progress is to be made in the field of psychologic medicine, it must be made by means of the recognition by other specialists of the psychologic factors and their readiness to deal with at least the simpler and more obvious, though sometimes overlooked, factors. The recognition of the unity of the patient, the fact that the patient who comes to the physician is a whole person made up of various organ systems, all of them functioning in a body which in turn is impinged on by external influences of the physical environment and in the form of social and interpersonal forces, influences to which that person is reacting as a unit, is essential, whatever the physician's specialty. The patient's fears, his anxieties, his frustrations, his aggressions, his conflicts and his feelings of guilt must all be taken into account if we mean what we say about the unity of the organism. There is no doubt that this recognition is becoming widespread in the specialty which deals with some of the tangible and demonstrable physical means of healing, namely, physiatry. Much progress has been made, but much room still remains for research, research which can well be carried on jointly by the psychiatrist and the physiatrist.

1. Watkins, A. L., and others: Psychiatric and Physiologic Studies on Fatigue, Arch. Phys. Med. 28:199, 1947.

ISOTOPES FOR MEDICINE

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This year marks two important anniversaries for radioactivity in the fields of biology and medicine: (1) the golden anniversary of the discovery of radium for use in radiation treatment and (2) the silver anniversary of the use of radioactive atoms for tracing stable atoms—that is, of the tracer atom technic.

Fifty years ago radium was discovered by Pierre and Marie Curie in France. This led to the wide and valuable use of radioactivity for radiation treatment of certain diseases, particularly cancer. Twenty-five years ago Hevesy in Denmark first used radioactivity to trace the course and behavior of a stable element in a biologic system. This was the inception of the technic of tracing the atoms of stable elements by means of their radioactive counterparts—the radioactive isotopes of that element. The first tracer experiments were done with the naturally occurring radioactive isotopes and were limited to the tracing of the heavy elements lead and bismuth.

As long as radioactivity was a phenomenon found only in the heaviest elements—elements which have little or no presence in biologic material, the use of radioactivity for purposes of treatment or tracer studies was limited in scope. Then came the miraculous discovery by Curie and Joliot in 1934 that ordinary elements, which in nature are found in the stable state, can be induced to become radioactive. It was soon observed that radioactive isotopes could be formed of nearly all the elements. This includes most of the elements that occur in biologic material. The door was thus opened to a wide variety of new possibilities for research and application in biology and medicine.

This was like the fulfilment of a cherished dream. Now investigators had at their disposal radioactive atoms of a wide variety of elements which could be applied in unique ways to biologic and medical problems. The man-made radioisotopes offered new ways of delivering radiation treatment directly to various tissues of the body, as well as a means of following atoms in the thousands of complicated reactions which go on in the human body, either healthy or diseased.

This door to new medical knowledge and application, opened by the advent of artificially produced radioisotopes, did not, however, open wide at first. The man-made radioisotopes could be made in significant quantities only by the use of very high energy nuclear bombardment devices or "atom smashers" such as the cyclotron. Not only were these devices limited in number but the amounts of radioactive materials produced were not sufficient for wide scale application and were rather expensive.

A vastly wider opening of the door into the new world of opportunity in medical research and application became a possibility with the operation of the first successful chain reaction in uranium—the operation of a "nuclear reactor" or "atomic pile"—a development of the wartime atomic energy project. This possibility, however, was not immediately capable of realization because of the secrecy and special purpose which surrounded the wartime program. Actually the new door was really opened wide for the first time just two

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years ago, in June 1946, when it was announced that pile-produced radioisotopes would be made available outside the atomic energy project.

Thus, although we have come to the golden and silver anniversaries of the start of two important uses of radioactivity, we are now just coming to the second, or "cotton," anniversary of the wide scale opportunity to realize all the possibilities that radioactive atoms offer in biology and medicine.

I do not wish to generalize further on the subject in this paper. Rather I will give some specific data on the distribution of isotopes for medical and biologic purposes accomplished during the two years of the project's isotope program. Also I will note briefly some examples of the uses actually being made of isotopes in medical research, diagnosis and treatment.

For the first twenty-two months of the distribution of pile-produced isotopes, i. e., from Aug. 2, 1946, to May 30, 1948, I have the following data for the number of shipments, number of using institutions and number of individual projects in which the isotopes are being employed.

Total Number Shipments
1. For studies in animal and human physiology and medical therapy—2,103
2. For all fields of study—2,901
3. For all fields now over 200 per month

Number of Institutions Using
1. Phosphorus 32 in medical therapy—43
2. Iodine 131 in medical therapy—38
3. Radioisotopes in medicine and biologic studies—119
4. Radioisotopes in all fields of study—229

Number of Individual Projects
1. In medicine and biologic studies—over 700
2. In all fields of study—over 1,400

It is evident that the major share of the shipments of isotopes are for investigations in medical therapy and in studies in animal and human physiology. The combination of these two accounts for over 70 per cent of all the shipments. Other biologic uses (studies in plant physiology and bacteriology) account for about 6 per cent of the shipments. The remaining fields of use —chemistry, physics, industrial research and metallurgy —account for about 20 per cent of the shipments.

One reason for the large number of shipments in medical therapy is that the radioisotopes being used, largely P^{32} and I^{131}, are of short half-life, approximately fourteen and eight days respectively. The same situation exists to a large extent in the case of studies of animal physiology. If the data are analyzed in terms of number of individual projects rather than shipments the greatest use is still in the fields of medical therapy and studies of animal and human physiology, but these two fields then account for about 50 per cent of the total.

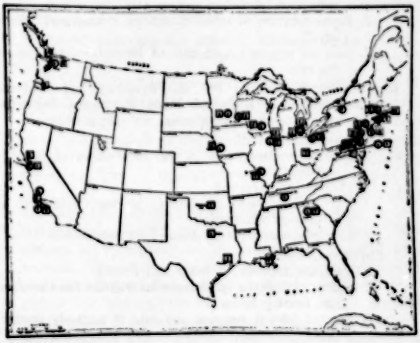
Of the radioisotopes used in medical therapy, I^{131} and P^{32} account by far for most of the shipments. The number of shipments of I^{131} slightly exceed those of P^{32} largely because the half-life of I^{131} (eight days) is shorter than that of P^{32} (fourteen days). Because of the greater rapidity of decay of I^{131}, shipments are required more frequently. In the first twenty-two month period, a total of over 30,000 millicuries each of I^{131} and P^{32} have been distributed. Only a very limited use of other isotopes has been made for experimental therapy, namely, of gold 198, calcium 45, strontium 89 and cobalt 60.

In studies of animal and human physiology, most use is made of three radioisotopes, iodine 131, phosphorus 32 and carbon 14. The number of shipments is in the order I^{131}, P^{32} and C^{14} largely because the length of half-life increases in this order. The actual number of using projects, however, is about the same for all these three isotopes, with P^{32} somewhat in the lead. In addition, sulfur 35, sodium 24, potassium 42, iron 55 and 59 and calcium 45 have been used extensively.

Shipments of pile-produced radioisotopes for therapy and medical research are being made to about thirty states. Most of these states are east of the Mississippi River. The largest number of shipments for therapy is to New York state, and Massachusetts, Minnesota, Pennsylvania, Ohio, California and Texas follow along closely with somewhat decreasing number.

With respect to the number of shipments for medical research, Massachusetts leads, with New York, California, Ohio, Illinois and Michigan following closely. The number of shipments for bacteriologic research are much smaller than for the other two fields, with California in the lead and Maryland, Illinois and Connecticut following, in that order.

The greatest number of shipments have been received in the Northeast area, largely because there are a greater



Geographic location of institutions using radioiodine and radiophosphorus for medical therapy. The location of phosphorus users (total 43) is indicated by a square and iodine users (total 38) by a circle. The figure in the square or circle indicates the number of institutions at that location which are using the materials for medical therapy.

number of academic and research institutions and a higher population in that section of the country. Another important reason, however, is that before the war there were a considerable number of cyclotron laboratories distributed throughout the Northeast, and these helped to institute the use of radioisotopes in the immediately surrounding regions. Accordingly, after the war, when pile-produced isotopes became available, the institutions and persons that had previously had experience with cyclotron-produced isotopes were most readily able to take advantage of the new opportunities. California, which was the birthplace of the cyclotron, is one of the states leading in the number of shipments received.

In the figure is shown the geographic location of institutions using radioiodine and radiophosphorus for medical therapy. The figure does not attempt to show the locations of all the hundred and nineteen institutions spread throughout thirty states, which are using radioisotopes in medicine and biologic studies.

It is to be noted that the using institutions cluster around the largest centers of population. New York

city leads, with the largest number of using institutions, with Philadelphia and Boston next. It is evident here again that the institutions which were previously in the vicinity of operating cyclotrons before the war have been those most immediately able to engage in the use of pile-produced radioisotopes.

It is difficult to give a complete picture of the varied ways in which radioisotopes are being used in approximately seven hundred projects concerned with medicine and biology. I will try, however, to give a partial indication of the scope and importance of all the uses by a few selected illustrations of actual uses. These are outlined briefly for the isotopes iodine 131, phosphorus, 32, carbon 14, sulfur 35 and calcium 45.

Illustrations of Uses of I^{131} in Physiology and Medicine

Diagnosis

1. Disorders of the thyroid gland
2. Thyroid carcinoma and metastases
3. Localization of brain tumors with diiodo-fluorescein

Treatment

1. Hyperthyroidism
2. Thyroid carcinoma and metastases

Research

1. Physiology of liver and gallbladder with labeled tetraiodo-phenolphthalein sodium salt
2. Renal function in terms of labeled iodopyracet "clearance"
3. Rate of entrance and exit of labeled iodopyracet in the eyes

Illustrations of Uses of P^{32} in Physiology and Medicine

Treatment and study of blood dyscrasias—leukemia, lymphosarcoma, polycythemia, multiple myeloma

Metabolic studies

1. Labeled nucleoprotein in the metabolism of bacteria and host tissues
2. Phospholipid synthesis
3. Exchange of radio phosphorus by bones and teeth as a function of nutrition
4. Labeled malaria plasmodium—host relationship

Physiologic studies

1. Vascular capacity in heart and kidney
2. Effect of digitalis on phosphorus transfer from medium into beating heart
3. Fate of labeled antigens and rate of antibody production
4. Permeability of skin and placental tissue to labeled phosphatides
5. Effect of anterior pituitary growth hormone on phosphate balance

Illustration of Uses of C^{14} in Studies of Physiology

Metabolic studies

1. Protein metabolism with labeled amino acids—leucine, glycine, lysine, (α)-amino adipic acid, alanine
2. Carbohydrate metabolism with labeled intermediates—lactic, pyruvic, oxalacetic and proprionic acid
3. Fate of labeled fats
4. Role of steroids and estrogens with labeled cholesterol, progesterone and diethylstilbestrol
5. Fate of labeled urethane as a possible therapeutic agent for leukemia
6. Fate of carcinogens with labeled methyl cholanthrene and 1, 2, 5, 6-dibenzanthracene

Pharmacologic studies

1. Action of labeled "benadryl hydrochloride" (diphenhydramine hydrochloride), "dilatin sodium" (diphenylhydantoin sodium), digitoxin, morphine, codeine, nicotine, colchicum and atropine
2. Fate and localization in nervous system of labeled barbiturates

Illustrations of Uses of S^{35} in Physiology

Metabolic studies

1. Protein metabolism with labeled amino acids—cystine, cysteine, methionine, glutathione

Pharmacology

1. Levels of labeled penicillin in blood and urine
2. Rate of uptake of sulfur by cartilage, bone matrix and bone marrow
3. To determine absorbability of thioglycolic acid and its salts through skin
4. To determine factors influencing tissue distribution of labeled organic compounds containing sulfonamide linkages
5. To determine mode of action of sulfonamide drugs with labeled sulfanilamide

Illustrations of Uses of Ca^{45} in Physiology

Metabolic studies

1. Calcium metabolism relative to hypoparathyroidism and hyperparathyroidism
2. Calcium metabolism in eclampsia and preeclampsia

Physiologic studies

1. Calcium absorption in tissue, nerve, muscle, epidermis and intestine
2. Effect of vitamin D and thyroidectomy on calcium exchange and uptake
3. Calcium secretion in crop gland as a quantitative assay for prolactin

There are, of course, many more uses for these isotopes than shown in the outline. In addition, a wide variety of uses are being made of sodium 24, potassium 42, iron 59, cobalt 60, copper 64, zinc 65, silver 110 and gold 198.

I have had to omit an almost equally interesting story on the distribution and valuable uses of concentrated stable isotopes. Stable isotopes cannot, of course, be utilized, as radioisotopes are, for radiation treatment or for diagnosis which depends on detection at a distance, but they are useful for many tracer studies. As the result of wartime activities in the concentration of isotopes, there are now available through our facilities over one hundred concentrated stable isotopes of thirty-three elements. Of these, only heavy hydrogen (deuterium) and oxygen 18 are being used in biologic and medical investigations. Two other isotopes, carbon 13 and nitrogen 15, available from commercial sources, are also used extensively for such investigations. There remains, however, a wide selection of concentrated stable isotopes which may be useful in these investigations but for which some development is needed in technic.

I should mention also that investigators in foreign countries can obtain through the Commission twenty-nine radioisotopes of twenty elements, which are of particular value in biologic and medical studies. Although international distribution has been in effect for only nine months, shipments have been made to fourteen countries and already impressive results are being obtained in over a hundred individual projects.

Isotopes will come to be used by more and more groups as isotopic technics and applications take their destined place in laboratories and medical research centers everywhere along with other important but now routinely used tools of investigation. In the future, reports in which isotopic methods have been used as part of the investigational procedure will no doubt so completely permeate the literature and scientific meetings that such papers will no longer be set apart by special symposiums or by special reference in the title, any more than this is now done for papers in which a microscope is used. Just as microscopy and spectroscopy have become highly developed technologies for investigation, we are now nurturing and maturing an "isotopology." And, just as it is now routine to speak of spectroscopists, we will have technicians known as "isotopologists."

In this connection one should remark that research using isotopic technics is not a goal in itself. Also, the use of isotopes is no substitute for thinking and effort. First, the investigator must have a problem involving the transfer of atoms, or transport and transformation of molecules, which would be difficult or impossible to solve by already available technics. Second, he should examine the usefulness of isotopes as a tool in solving the problem in conjunction with employment of his existing methods. Complicated problems nearly always involve a carefully combined attack with all the applicable technics. Isotopic technics will give new and trustworthy results only as an added power of perception used with other complementary technics.

The Atomic Energy Commission, is, of course, eager to promote progress in the proper and effective use of the isotopes which are available from its facilities. Much has been accomplished in making desired isotopes available in suitable form and quantity. No longer need a research problem or a technical application which is dependent on a producible isotope suffer from lack of availability of the isotope. Moreover, well developed technics and very satisfactory instrumentation for the various uses of isotopes have become generally available.

The main remaining deterrent to advances in knowledge which can be obtained by employing these powerful investigational tools is the unpreparedness of most research groups to take full advantage of all the available isotopes. The greatest need now is for dissemination of detailed information on the laboratory procedures of isotope applications and for making training in these applications readily available to interested scientists.

Progress is now being made in the information and training aspects of isotope applications. Several good books have appeared or will soon appear on isotopic technics. Journals are carrying an increasing number of articles on the procedures as well as the results of work with isotopes. A new journal devoted to "nucleonics" has even appeared, and it includes numerous technical articles on the use of isotopes. Several universities have given training courses in isotope applications and have sponsored rather complete symposiums in this field. More of such courses and symposiums are expected.

The Atomic Energy Commission will be giving increasing assistance to the dissemination of information and provision of training in the peacetime developments of atomic energy. Our office is providing circulars on many aspects of the use of isotopes, and the Commission now has an Office of Technical Information for effective dissemination of unclassified information in general. The Commission has initiated a system of fellowships for training in atomic energy developments and is assisting in the establishment of training centers.

In addition, our office has an Advisory Field Service the personnel of which visit isotope users and interested groups and give direct advice to them in their own laboratories on proper procedures for the safe and efficient use of radioisotopes. Although our personnel is limited, we will be pleased to offer whatever assistance we can. I urge physicians to write to us at the Isotopes Division, Atomic Energy Commission, Oak Ridge, Tenn., concerning available information and assistance on whatever problems you think may be best approached through the use of isotopes.

It should be pointed out that although atomic energy and radioactivity can be fraught with hazard, there is really a large body of knowledge and experience on how to control them. There is no need for unreasonable or unhealthy fear of radioactivity. Knowledge and a healthy respect are sufficient. Radioactivity can be detected with extremely high sensitivity and with comparative ease; consequently, safe conditions of work or application are easy to establish.

Over fifty years' use of radium and roentgen rays have demonstrated that both of these can be applied and handled safely. Radium and roentgen rays have revolutionized the field of medicine and are absolutely essential to its modern practice. Likewise radioisotopes can be applied and handled safely. They too will help to bring about revolutionary advances in medicine, and they also will become essential components of this art and science.

The infant field of isotope applications and the newborn program of isotope distribution are already doing a man-sized job and are on the way to herculean achievements.

THE MEDICAL PROFESSION AND ATOMIC ENERGY

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As a layman, I approach this symposium with considerable humility—aware of the easy opportunity for disaster, such as accompanied the lecture of a friend who had traveled in the South Seas and, on his return, spoke to an audience of engineers. He mentioned that when he was in the Trobriand Islands, he had been impressed by the clarity and translucence of the atmosphere. It was so clear, he said, that he could frequently see the natives standing in their dugout canoes at a distance of 10 miles. At the end of the lecture, one of the audience of engineers thanked him and commented that many present, competent to calculate for the curvature of the earth, had noted his remarkable discovery, that the natives of the Trobriands were 69 feet tall. Taking this lesson to heart, I will avoid any reference to technical matters, leaving them to be dealt with by my competent and distinguished colleagues, Dr. Shields Warren, Dr. Paul Aebersold and Dr. Stafford Warren, who take part in this program.

I would begin these brief remarks by observing that medicine has assisted at the birth of more than one of the physical sciences. The study of gases and the measurement of heat were once the exclusive province of physicians. Current electricity had its inception in medical research on nerves. It is in keeping with good precedent, therefore, that nuclear physics, the youngest of the physical sciences, should also benefit by the attention of the medical profession as life begins for it.

On the other hand, advancement in the physical sciences has regularly placed at the disposal of the medical profession new instruments, new problems and new means of solving those problems. Atomic energy has already begun to do so. And just as the progress of modern medicine may be said to date from Harvey's discovery of the circulation of the blood, so with the

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physical sciences, their real development began with the circulation of ideas and the free exchange of information.

The heart which provides the circulation of ideas and information in your profession, the American Medical Association, is the largest most representative body of persons charged by their choice of profession with responsibility for the health of the public. By virtue of the whole tradition of your membership, it has achieved and has accepted a position of great public trust. This position imposes a solemn and unusual obligation. A physician accepts, as his established duty, giving a part of his time, often at substantial loss, to teaching others, improving his own ability to serve and aiding in solving the health problems of his community. Medicine was probably the first science to be recognized as such, obviously because it had a vital and practical importance to every citizen. For centuries it has enjoyed special prestige and, in consequence, has had special duties.

The development of atomic energy as a military weapon through our unique engineering and scientific competence poses to medicine new and rather fearful questions. The existence of radiation hazard on a large scale is a threat to life, health and reproduction. How to handle it is a medical problem, both in theory and in practice. It is timely and proper that the American Medical Association should consider certain aspects of atomic energy control which confront the nation and which specifically face the Atomic Energy Commission, the nation's deputy in this field.

These problems concern medicine as a science and men of medicine as individuals, not only because of questions of health in time of war but also because of certain social and administrative matters which surround the use of atomic energy in peace. These latter difficulties were originally faced by medicine as a discipline and have been solved by medicine in a peculiarly gratifying and exemplary way. I refer to the solution of such problems as useful cooperation between public and private agencies, the subordination of private interests for public good, the voluntary collaboration of scientific men to forward common and predominantly lay interests. Finally, and most important as an example, is the ability of men of medicine to unite for the attainment of practical ends through the scientific method and to be able to do this without loss of scientific freedom to continue undirected individual search for new concepts.

The first question to be answered concerning the future of atomic energy was one of its ownership. Was it exclusively military property because it was first employed in a major way by the military? Was it the property of the scientists who brought it into being? Certainly neither could be considered as having title any more than that healing science should be the sole chattel of the medical profession. The moment when knowledge becomes practical technical competence affecting the well-being of everyone, then at that moment title to this competence must pass to the public domain. The rights of the citizens as a whole should, and do, wholly transcend the rights of the individual in every major instance in which they may conflict. I believe that this is a fundamental and generally accepted principle in the democratic state.

Once the title to atomic energy is established in the public domain, the delegates of the public must decide how to handle this force in the public interest. Three factors seem to bear on this decision: First, what is needed? Second, what is practicable? Third, what is expedient? To answer these questions in detail obviously involves considerations which are outside the scope of a short discussion. A general statement may suffice. It could be worded somewhat as follows: We need to make atomic energy as useful as we can for peace and, at the moment, for possible war. Usefulness in both is certainly practicable. Moreover, within certain limits, usefulness is wholly expedient. Recall that these basic decisions are made in the public interest, after due consultation with special interests which I shall later mention.

When we have concluded that atomic energy can be made useful, we have simultaneously decided that our problem is an applied one and that our planning must be set up to convert an advance in pure science to practical ends. This conversion presents serious problems, since certain hurdles exist that must first be cleared. These are three in number and old and familiar; namely, prejudice, tradition and special interests.

Up to now, prejudice against work on atomic energy, based on lack of detailed information, has been a reasonably serious handicap. Atomic energy, long on our doorstep, burst on public consciousness with an appalling detonation. Many persons still assume that explosions and devastations are uniformly its concomitants. This is, of course, no more true than that because this great city was once destroyed by fire, milking by lamplight must always produce a holocaust. Atomic energy had two generations of quiet usefulness and life-saving behind it before atom bombs were ever dreamed of. It should have centuries of orderly and unsensational application in the future.

More serious perhaps than the thought of structural ruin from the atom is the widespread impression that atomic energy is a health hazard of monumental and enduring proportions. True enough, we know it can kill in a protracted and unpleasant manner. Certainly, persons can be injured by loose and restless atomic particles, and chromosomes can be damaged, with resultant mutations. But we should remember that these changes can be produced also by any number of agents from sunlight down to the garden crocus. In other words, they are neither very new, nor very startling. It is simply that our attention is focused on them at the moment. Happily, the facts are coming to be more widely understood and fear is being replaced, though slowly, by confidence. In future, we must equally guard against overconfidence.

Tradition is the next barrier. It is serious because it is deeply impressed on the minds of many of the men and women of science on whom we must depend to carry the task forward. The fundamental tenet of this particular tradition is that science is for the scientist. This was more nearly true at a time when the acquisition of knowledge, in fields other than medicine, was completely an end in itself. It is, of course, no longer true now that the lives and rights of free men everywhere are dependent on science. A scientific subject need not be completely abstruse in order to qualify for research.

The third hurdle in the development of a useful position for atomic energy is the existence of special interests in the scientific fields. These interests are

long established and strongly held. It is likewise of great importance that they be maintained. But they should be maintained in such a way that the early and intelligent development of the benign uses of atomic energy shall be pressed. These interests are, of course, the government departments, the industrial laboratories and the universities.

For instance, it is always simple to conceive of the creation of vast governmental laboratories, supposedly capable of solving the most refractory problems, by sheer weight of funds. But this procedure is not really an effective move, or even a desirable one, on the basis of peacetime experience. Federal departments are removed from the free enterprise system. Work in them is generally conducted on a high plane, with excellent facilities and talented personnel and often with distinguished results. They must, however, from their very bulk and permanence, be inflexible and should be. Their concern is to be right and to avoid errors. They are invaluable as reference and control activities. But science, being always unconventional, demands flexibility and unorthodoxy. These are the concomitants of competition, incentive and daring. Usually they are not found, and do not belong, in government enterprise.

On the other hand, the industrial laboratories know the value of ingenuity. They have highly developed the incentive motives and thereby have acquired staffs of great competence, admirable equipment and smooth flexible organization. These groups are ideally constituted for the conversion of fundamental knowledge to direct application. That is their business. They have, however, a serious handicap which makes their exclusive use in an activity as extensive and vital as atomic energy unworkable. This handicap is not, as is sometimes supposed, the fact that they must earn profits for stockholders. A proper profit always must be found in private operation for public ends. The real handicap for an exclusively industrial approach is the impossibility of adequately rewarding key personnel. In short, the use of the patent system to reward the inventor for brilliant strikes, profoundly implicit in the operation of commercial laboratories, is out of the question where atomic energy is concerned, at least as far as one can see ahead.

The third interest is the university. The university, as the traditional trustee of learning and the vigorous defender of free unprejudiced thought, must have a predominant consultative role in any important scientific public enterprise. This was recognized as early as when President Lincoln created the National Academy of Science to advise the federal government in learned matters. The principle has expanded in the use by federal agencies of advisory bodies, largely drawn from university circles. But advisers with this background may be expected to have a tendency to resist the lay demand for quick practical return, in terms of things, for the very practical outlay of large sums of money taxed from the lay public.

SUMMARY

I have tried in this necessarily brief paper to sketch an outline of some of the problems of atomic energy development in the United States. They bear, it seems to me, some similarity to the problems and responsibilities which have been faced by medicine for many years. They have been solved by medicine by a professional acceptance by its members of an obligation to public service. The recognition of this sort of obligation establishes an important and timely precedent. It is one which was invoked successfully for science as a whole during the war, and it must become the touchstone of obligation for citizenship on the part of gifted persons in the era of atomic peace.

MEDICAL PROGRAM OF THE ATOMIC ENERGY COMMISSION

SHIELDS WARREN, M.D.
Boston

In this symposium, you have heard varying aspects of the relations of atomic energy to the field of medical science. The advent of atomic energy, as you can well see from the foregoing presentations, has had its impact not only on the political structure of the world but on its scientific and medical makeup as well.

You and your fellow citizens have given the Atomic Energy Commission the responsibility of insuring that the best possible use of this new source of energy will be made, consistent with the national security.

The last six years have seen more profound changes in scientific medicine than any period since the discovery of bacteria or the invention of the microscope. The changes have been brought about by many factors: the wholesale uprooting incident to the war, the development of antibiotics, the impact of social legislation and, above all, the advent of atomic energy. When we consider that before the war scattered persons received localized radiation in the hospitals and in physicians' offices, whereas hundreds of thousands were killed or exposed to ionizing radiations at Hiroshima and Nagasaki; when we think that six years ago the average man had no more concern with ionizing radiation than as a means of checking on an aching tooth or determining the cause of chronic cough, whereas today millions of persons live within the shadow of possible wartime exposure to ionizing radiation from the atomic bomb, and when we realize that six years ago it would be a skilled chemist who could detect after hours of work a millionth of a gram of phosphorus and now a technician with a Geiger counter can detect a fraction of a millionth of a gram of radioisotopic phosphorus in a few minutes, we realize how long a road we have come in this short span.

As a result of the atomic bomb in Japan, the Bikini test and the lowering clouds of war, it is natural that we think of atomic energy in terms of mass destruction, mass destruction cheaper and more efficient than any other then envisaged. However, like the old coin with the eagle and clutched arrows on one side and the head of Liberty on the other, this picture of atomic energy has a fair and forward-looking obverse. What atomic energy may bring about in the way of development of power and of heat, what it may do in the propulsion of ships or aircraft remains all but hidden in the mists of the future. What it means as a provider of research tools is at present as overwhelming as a streamliner rushing down on a grade crossing.

EXTERNAL RADIATION AND INTERNAL RADIATION

In any consideration of radiation, it is important to remember that ionizing radiation may affect the body in two ways: first, as external radiation, as from the

Read in a symposium on Atomic Energy in the General Scientific Meetings at the Ninety-Seventh Annual Session of the American Medical Association, Chicago, June 22, 1948.

conventional x-ray tube, and, second, as internal radiation, as from the administration of radioactive phosphorus.

The various ionizing radiations affect cells qualitatively in similar fashion. There is no way that one can tell by examination of a cell or tissue whether the radiation effect seen has been produced by neutrons, by 200 kilovolt roentgen rays or by the gamma rays of radium. The predominating effect is assumed to be through interference with the nucleic acid metabolism of the cell. External radiation, in passing through the body, has an almost equal chance of being absorbed by the various cells with which it comes in contact. The quantitative variation that these cells show in response hinges chiefly on their inherent sensitivity to irradiation. In internal radiation, on the other hand, because of the specific affinity of certain tissues for specific elements, as, for example, bone and phosphorus, or thyroids and iodine, and because of the relatively short range of many of the types of radiation emitted by the various isotopes, there can be some degree of selective localized radiation.

RADIOACTIVE ISOTOPE THERAPY

In radioactive isotope therapy there is an attempt to take advantage of these selective localizations. In determining the therapeutic value of any radioactive isotope, there are several factors to be taken into consideration: first, the inherent toxicity of the substance itself—thus, strontium, which might be useful because of its high toxicity to bone marrow. Second, the half-life of the material: material which has a long half-life is much more dangerous from the standpoint of possible excessive radiation than one with a short half-life. On the other hand, problems of shipment and preparation of the material for administration demand a certain amount of time, and material with too short half-life would not be satisfactory. Third, the degree of localization; for example, radioactive sodium is relatively limited in use because of the high degree of diffusibility of the sodium ion. Fourth, range and type of radiation which tend to limit the region effectively irradiated to the vicinity of localization. Fifth, the element must be such that its specific activity can be reasonably high, preferably in the order of 1 millicurie per milligram of element. Thus, radioactive calcium with a half-life of forty-five days might be a fairly suitable material from the therapeutic standpoint; however, the specific activity of calcium is relatively low and, consequently, it is difficult to get an effective concentration of the isotope at a desired point. There are relatively few substances that fulfil all these desirable criteria.

There is also an important set of variables from the standpoint of the lesion to be treated. First, the lesion must be one that may be satisfactorily treated by ionizing radiation, that is, its cells must be responsive to radiation; second, there must be a fair differential between the sensitivity of the abnormal and the normal cell of the part.

In the light of these limitations, it is not surprising that only a few isotopes among those thus far tried have been useful from the standpoint of treatment. These are radioactive phosphorus in the case of polycythemia vera, and some leukemias; iodine^{131} in rare carcinomas of the thyroid and gold^{199} in some malignant processes in which either direct injection into the tumor is utilized or the selective uptake of colloidal substance by the reticuloendothelium system is of value.

MEDICAL PROGRAM

The medical program of the Atomic Energy Commission may be divided into four parts: First, the maintenance of health of the workers of the commission and its contractors. Thus far, the health and safety record is an enviable one, and speaks highly for the foresight of those who set the initial standards of safety and permissible dose levels for exposure to ionizing radiation. Second, the protection of environmental health. This involves such problems as waste disposal, possible contamination of surrounding areas and the like. Third, the development of basic research in those problems peculiarly related to atomic energy, of which the effect of ionizing radiation on the plant, animal and human cell, both isolated and aggregated into organisms, must be determined. Such problems as permissible dose levels of ionizing radiation, metabolism of new or rare elements, the mechanism of radiation injury, the development of treatment for such injury and the character and mode of development of hereditary changes due to ionizing radiation are among those of basic importance. Fourth, the exploration of what, if any, values the new sources of energy available at the installations of the Atomic Energy Commission themselves and the value that very short-lived radioactive isotopes may have in cancer research and cancer therapy.

An important aspect of the cancer research program is the free provision of the isotopes thus far established as most definitely of value, namely, phosphorus^{32}, iodine^{131} and soduim^{24}, for cancer research and cancer therapy. It is hoped that this list may later be enlarged to cover other important materials. Cobalt^{60} is receiving careful consideration at the present time. It is of special interest, owing to the fact that the gamma radiations from cobalt are essentially the same as those from radium, since cobalt has a moderately long half-life of five and three-tenths years, and, since it is nontoxic as an element, its use offers certain definite advantages. Of particular importance is the fact that it is not an alpha particle emitter and is not stored indefinitely in bone, as in the case of radium and radon.

Finally, since no program can hope to be better than the personnel by which it is being implemented, training plays a very important part. To this end and to compensate partly for the dirth of scientific personnel due to the war, a fellowship training program is being developed in the medical and allied sciences. This training program, administered by the National Research Council for the Atomic Energy Commission, provides up to one hundred predoctoral fellowships annually and seventy-five postdoctoral fellowships annually in the life sciences.

The predoctoral fellowships are one year in duration and are renewable. The postdoctoral fellowships have a term of two years and are not renewable. The greatest latitude compatible with sound training will be offered the fellow in obtaining his training, whether in the installations of the Atomic Energy Commission or whether in a university or a hospital. One feature of the predoctoral fellowships is their availability to medical students who may desire to interrupt their training, particularly at the end of the second year, for a year of fundamental research in this new field.

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Council on Physical Medicine

REPORTS OF THE COUNCIL

The Council on Physical Medicine has authorized publication of the following reports. HOWARD A. CARTER, *Secretary.*

PRESS-AIRE PRESSURE AND VACUUM PUMP ACCEPTABLE

Manufacturer: Press-Aire Products, 909 E. Willetta, Phoenix, Ariz.

The Press-Aire Pressure and Vacuum Pump is a device designed to furnish relatively small positive or negative pressures such as might be used clinically for aerosol therapy. It takes up space amounting to 16.5 by 11 by 17 cm. (6½ by 4¼ by 6¾ inches) and weighs 3.9 Kg. (8½ pounds). The shipping weight is 4.1 Kg. (9 pounds). It draws 132 watts (1.2 amperes) on a 110 volt 60 cycle alternating current.

Press-Aire Pressure and Vacuum Pump.

The descriptive folder states that the pump can furnish a maximum air pressure of 15 pounds (per square inch, equal to 775 mm. of mercury). This claim was verified in a laboratory acceptable to the Council, where the pump gave more than 789 mm. The folder similarly claims a maximum vacuum of 16 inches (presumably inches of mercury, equal to —406 mm.). This claim was also verified by the laboratory, where the pump gave —439 mm. of mercury.

The Council on Physical Medicine voted to include the Press-Aire Pressure and Vacuum Pump in its list of accepted devices.

LIFE LITE COLD QUARTZ ULTRAVIOLET LAMP, MODEL R-6, ACCEPTABLE

Manufacturer: Ultra Violet Products, Inc., 5205 Santa Monica Blvd., Los Angeles 27.

This ultraviolet generator is of the high potential, low vapor pressure, "cold quartz," mercury arc type. The burner, which is a fused quartz tube, 7 mm. in diameter, about 180 cm. (6 feet) long, wound in a flat hexagonal spiral, is supported in a hemispherical reflector 30 cm. (12 inches) in diameter.

Life Lite Cold Quartz Ultraviolet Lamp, Model R-6.

The reflector is supported on the end of an arm that is free to travel horizontally and rotate about the axis of the arm. This arm is mounted on a vertical telescoping column that is adjustable in height from 75 cm. to 132.5 cm. (30 to 53 inches). The vertical column is attached to a substantial base that houses the high voltage transformer.

The lamp operates on 110 to 130 volts, with an average power consumption of about 35 watts. The exposures are timed by an automatic clock-controlled switch.

Mechanical, electrical, radiometric and physiologic tests on this lamp indicated that about 90 per cent of the biologically effective ultraviolet radiation of wavelengths 3,132 angstroms, and shorter was in the wave band centering about 2,537 angstroms, and that at the standard distance of 61 cm. (24 inches) from the plane of the rim of the reflector on 120 volts (38 watts) the intensity was close to 750 microwatts per square centimeter. This is about twenty times the minimum intensity specified in the published statement of requirements for Council acceptance of such lamps, which stipulates an exposure of 45 seconds for a minimum perceptible erythema.

The Council on Physical Medicine voted to include the Life Lite Cold Quartz Ultraviolet Lamp, Model R-6, in its list of accepted devices.

MICROTONE AUDIOMATIC T-3 HEARING AID ACCEPTABLE

Manufacturer: The Microtone Company, 4602 Nicollet Avenue, Minneapolis 9.

The Microtone Audiomatic T-3 is a battery-contained hearing aid. The white plastic case contains the microphone, amplifier and batteries. The outside dimensions are 122 by 62 by 24 mm. (4 13/16 by 2 7/16 by 15/16 inch) exclusive of the clip and the attachment of the cord to the receiver. The A battery and the 30 volt B battery are both of the zinc-carbon type. The A battery drain is 60 milliamperes and the B battery drain is approximately 0.55 milliampere.

Microtone Audiomatic T-3 Hearing Aid.

The instrument is of sturdy construction. The following results were obtained in a performance test:

Subject	Acoustic Gain	Articulation Scores Microtone	Reference
A	Not Observed	80%	80%
B	Not Observed	75%	77%
C	46 db.	Not Observed	
D	49 db.	Not Observed	

The Council on Physical Medicine voted to include the Microtone Audiomatic T-3 Hearing Aid in its list of accepted devices.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M.D., *Secretary.*

PENICILLIN (See New and Nonofficial Remedies 1947, p. 144).

The following additional dosage forms have been accepted:

PREMO PHARMACEUTICAL LABS., INC., SOUTH HACKENSACK, N. J.

Tablets Crystalline Penicillin G Potassium (Buffered): 50,000 and 100,000 units. Buffered with calcium carbonate 0.25 Gm.

Troches Crystalline Penicillin G Potassium: 5,000 units.

PROPYLTHIOURACIL (See THE JOURNAL, Oct. 9, 1948, p. 429).

The following dosage form has been accepted:

ELI LILLY & CO., INDIANAPOLIS

Tablets Propylthiouracil: 50 mg.

DIGITOXIN-U.S.P. (See New and Nonofficial Remedies 1947, p. 249).

The following dosage form has been accepted:

THE WM. S. MERRELL CO., CINCINNATI 15

Tablets Unidigen: 0.1 Gm.

STREPTOMYCIN (See New and Nonofficial Remedies 1947, p. 150).

The following additional dosage form has been accepted:

PREMO PHARMACEUTICAL LABS., INC., SOUTH HACKENSACK, N. J.

Streptomycin Sulfate: Vials containing streptomycin sulfate equivalent in activity to 1 Gm. of streptomycin base.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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SATURDAY, DECEMBER 25, 1948

THE ASSESSMENT AND PUBLIC OPINION

Chief among the subjects discussed by doctors since the interim session of the House of Delegates in St. Louis has been the assessment of twenty-five dollars per member voted at that session. Few indeed are adverse comments from members of the medical profession. Most physicians who have expressed their views feel that they want to participate fully in the campaign of education that will be financed by these funds. Some few physicians have said that they do not favor the assessment.

Opposition to the point of view of the medical profession of long standing, such as that from the Committee on the Nation's Health, Senator Murray, Congressman Dingell and the so-called Committee of Physicians for the Improvement of Medical Care, Inc., might have been anticipated; they are merely running true to form; their strength is but little either in numbers or in medical support. From many of the state medical societies has come enthusiastic official endorsement of the action taken by the House of Delegates; this has been most heartening to those who will have the burden of determining the actions to be taken.

One state has circularized the official bodies of the Association, including many of the delegates, with its concept of the form that the program should take. In addition, literally hundreds of advertising agencies, purveyors of radio time, public relations counsels, experts in propaganda, motion picture producers, publishers and similar groups have besieged the headquarters of the Association with proposals which might utilize a considerable share of the funds when they become available. It would be inconsistent with the status, the prestige and the tradition of the American Medical Association to approach this problem in a confused or disorderly manner. The procedure since the House of Delegates passed the resolution endorsing the assessment has been strictly according to proper organizational action. The Board of Trustees announced to the House of Delegates the establishment of a special committee to be known as the Coordinating Committee for the Protection of the People's Health, composed of members of the Board of Trustees and of the House of Delegates; on this committee will rest the responsibility for ultimate decisions. The executive committee of that group employed the firm of Whitaker and Baxter of California as special public relations counsel. This firm had previously acted as counsel for the California Medical Association in its presentation of the point of view of the medical profession in relation to compulsory sickness insurance in California. At present Whitaker and Baxter are developing a comprehensive program of education, which will be submitted to the entire Coordinating Committee at its second meeting on January 8.

The American people have not as yet heard specifically of the purpose for which the funds will be used. Again, as might have been anticipated, some newspapers referred to the assessment as "war chest," others as a "slush fund," even more as the basis for a vast lobby. None of these appellations is justified. As was directed by the House of Delegates, the special fund will be employed to educate the American people as to the nature of medical practice in the United States, as to the services rendered by the medical profession and as to the program of the American Medical Association for extending medical research and medical care. No doubt all the usual mediums of public education will be utilized. Emphasis will be placed on the ideals of the American medical profession. Certainly the American people should know that compulsory sickness insurance is not a technic for providing free medical care to all of the people but instead a system whereby the workers of the nation are taxed to support a vast bureaucracy which itself will distribute medical care and which will be the intervening agency between the sick and the medical, hospital, pharmaceutical, nursing and allied professions. An educational campaign of the scope contemplated will reach to the very grass roots of the nation. Every physician and every medical organization can aid in this educational project by further interpretation and education of patients and public groups.

As might also have been expected, because the campaign against compulsory sickness insurance has been going on since 1916, many a medium of public information, many an official of county, state and national government, many a leader of industry, finance, transportation and banking has rallied to the cause of the medical profession. Innumerable offers have come to the headquarters of the Association of space in periodicals and in the press, time on the radio and similar facilities for the campaign of extension of knowledge to the people. Many organizations allied to medicine have indicated their firm support of the program of the medical profession and have offered to participate with funds, with speakers and with their other facilities. In view of this situation leaders of the medical profession in the individual states need not be overcome by apprehension or fear. They need only to recognize the necessity for such leadership as the Coordinating Committee must provide. They should recognize the desirability of a well coordinated

program under such leadership rather than a state of confusion with innumerable leaders widely scattered throughout the country and out of intimate contact with the central organization.

In the time that has elapsed since the House of Delegates met, certain members of the established opposition have been, as usual, expressing their points of view wherever they could gain an audience. The Committee on the Nation's Health, under the presidency of Channing Frothingham, has issued several bulletins. The Committee of Physicians for the Improvement of Medical Care, Inc., has sent out its Statement No. 25. These thirty-five physicians do not choose to agree with many of the actions of the representative body of American medicine.

Mr. Ewing, Federal Security Administrator, has, for reasons known only to himself, taken to the hustings; he has appeared on several radio programs, forums and platforms in promotion of compulsory sickness insurance. Some physicians have thought that the American Medical Association, through its president and secretary, ought to be answering every one of the statements that have been issued by the people already mentioned and also by Senator Murray, Congressman Dingell and others.

The St. Louis *Globe-Democrat* has directed a pointed inquiry at these activities on the part of Mr. Ewing. A few paragraphs are worthy of quotation:

> Ewing, who presumably is hired solely to 'administer the Social Security set-up as dictated by present laws, has gone all-out on a lobbying expedition against the lobbying plans of the A. M. A. against socialized medicine. Though ethics would seem to decree that he stick to his legal chores, he is feverishly denouncing A. M. A.'s "frantic taxation of members to finance the greatest lobbying effort in history." Curiously, he is condemning others for the kind of congressional pressure for which his and federal social reform departments have long been noted. It is all very confusing. Bureaus, it now seems, are supposed to tell Congress what to do; not be content merely to carry out the laws it passed.
>
> As an individual he has, of course, the right of free speech, but when he says categorically that President Truman's election gave socialized medicine the green light, he ought to state it merely as an opinion and not as a fact to excuse his wild haymakers.
>
> This appears to be the beginning of a gigantic compulsory health insurance campaign which Ewing is reported "coordinating." Rumors say the attacks will accuse doctors of charging outrageous fees the average citizen cannot afford, of shuttling him expensively back and forth between specialists, of supervising medical education in such a way as to insure a continued shortage of physicians, and of failing to attempt to remedy the poor distribution of medical talent over the nation.
>
> But won't such a campaign be expensive? If so, whose slush fund is Ewing co-ordinating? Or will the work be done by regular FSA and Public Health Service employes whose salaries are paid by taxpayers who oppose as well as favor socialized medicine.

In the same editorial the *Globe-Democrat* recognizes the right of the American Medical Association to assemble any sum it may wish to assemble to battle the Ewing program, but it also points out that perhaps a goodly portion of funds might be used to "hunt ways to remedy the conditions Ewing and others properly decry." The *Globe-Democrat* may be assured that a definite portion of the effort of the American Medical Association at this time is designed to develop exactly such remedies.

This then is the present status of the assessment and of public opinion concerning it. The medical profession of the nation should recognize that there is no panic, no fear, no doubt in the minds of the leadership of the American Medical Association. The Coordinating Committee is proceeding in an orderly, scientific manner to do the task assigned to it by the House of Delegates.

GLUTAMIC ACID AND INTELLIGENCE

Experimental studies during the past twelve years have suggested that glutamic acid may bear some unique relation to the normal functioning of the brain. In 1936, the English worker Weil-Malherbe [1] demonstrated that slices of the gray matter of rat and guinea pig brain will oxidize *l*-glutamic acid, the naturally occurring form, but would not oxidize the *d*-form, or any of twelve other amino acids studied. This investigation suggested that glutamic acid played some important part in brain metabolism, perhaps in the utilization of carbohydrate for energy. More recently it has been observed [2] that *l*-glutamic acid increases formation of acetylcholine in extracts of rat brain, and still others have found that *l*-glutamic acid administered to rats enhances their ability to learn a simple maze [3] and a somewhat more complicated problem box.[4]

Studies on the possible effect of glutamic acid in human subjects with various types of dysfunction of the brain have logically followed the foregoing suggestive experimental observations. That glutamic acid exerts a favorable effect in decreasing the frequency of petit mal seizures in epileptic patients now appears to be fairly well established,[5] and the effect is claimed to be due to some other factor than an alteration of acid-base balance.[6] Another unexpected observation in the epileptic patients was an increased mental alertness,[5] a result which is in general accord with those obtained in experimental animals as mentioned.[7] A further logical extension of the problem was, therefore, to study the effect of glutamic acid on the intelligence of mentally retarded human subjects. Two such recent studies [8] have indicated some favorable response; using standard psychologic tests as criteria, these investigators have observed a rise in "mental age" and intelligence quo-

1. Weil-Malherbe, H.: Biochem. J. **30**: 665, 1936.
2. Nachmansohn, D.; John, H. M., and Waelsch, H.: J. Biol. Chem. **150**: 485, 1943.
3. Zimmerman, F. T., and Ross, S.: Arch. Neurol. & Psychiat. **51**: 446, 1944.
4. Albert, K. E., and Warden, C. J.: Science **100**: 476, 1944.
5. Price, J. C.; Waelsch, H., and Putnam, T. J.: J. A. M. A. **125**: 1153, 1943.
6. Waelsch, H., and Price, J. C.: Arch. Neurol. & Psychiat. **51**: 393, 1944.
7. Zimmerman and Ross.[3] Albert and Warden.[4]
8. Albert, K. E.; Hoch, P., and Waelsch, H.: J. Nerv. & Ment. Dis. **104**: 263, 1946. Zimmerman, F. T.; Burgemeister, B. B., and Putnam, T. J.: Am. J. Psychiat. **104**: 593, 1948.

tient in the patients and a general improvement in mental functioning. The improvement was not restricted to any one segment of intelligence and personality; it was greatest within six months of beginning therapy and diminished after that. The "ceiling effect" appeared after one year of treatment.

Although current work [9] challenges the earlier claim that glutamic acid improves learning in the rat, further careful studies of this question are clearly warranted. Any therapeutic measure which offers even a glimmer of promise in conditions heretofore as apparently hopeless as these mental deviations merits full and objective consideration.

Current Comment

NEW HEALTH REGULATIONS FOR IMMIGRANTS

The workings of the legal mind are frequently difficult for the scientific mind to understand. According to a recent report, an alien arriving in the United States who wishes to become a permanent resident must provide evidence of freedom from venereal disease in the form of a certificate signed by a physician and a roentgenogram of the chest to indicate freedom from tuberculosis. The new rules do not apply to aliens who come for visits or for business reasons and who may stay as long as six months. In the case of war brides, they must be admitted even if they have venereal disease and/or tuberculosis, and local health officers in the areas to which they go are notified of their condition. Everyone arriving in the United States, including United States citizens returning from abroad, must have a certificate showing a recent vaccination against smallpox. Apparently casual visitors may spread their diseases at random. This should be a big help to the cause of good health.

PSYCHIATRIC REHABILITATION OF SELECTEES

The New York City Committee on Mental Hygiene [1] recently studied the extent and nature of psychiatric problems among men in New York city excluded from military service for neuropsychiatric disabilities. They proposed to determine the severity of handicapping, the numbers needing psychiatric help, the kinds of psychiatric help needed and the possibilities of reducing the gap between present needs and present resources for psychiatric aid. The study was made by interviewing 314 men rejected and 309 men discharged for neuropsychiatric disabilities. These were selected from ten selective service boards. Ten categories of disturbance were studied. However, the large majority of cases fell within the first two groups, viz., psychoneuroses and inadequate psychopathic personality. Among other interesting facts developed in the study, it was discovered that many of the men demonstrated to need psychiatric aid refused treatment because of the fear and scorn popularly associated with psychiatric disorders. The mention of psychiatry still suggests to most persons the "frightening implications of insanity and lunatic asylums." Interview responses from patients needing treatment contained rubber stamp phrases such as "nut doctor" for psychiatrists, and "Don't tell me I'm loco," and "I'm not wacky." Many patients during the course of the interview expressed great relief at the assurance that they were not "crazy" or "slaphappy" and subsequently agreed to undertake extended treatment. Many who were unwilling to admit the psychiatric nature of their complaints were willing to take medical treatment but not psychiatric treatment. The gap revealed between numbers of dischargees needing psychiatric help and those who would accept it was painfully large. However, the gap between those who needed help and those receiving it was much greater. Of those who needed help, only 26 per cent were willing to accept it and only 5 per cent were actually receiving psychiatric aid. Furthermore, 61 per cent of the men who need and want psychotherapy require free service and the remaining 39 per cent, with but few exceptions, could pay for only low cost care. The authors concluded that greatly increased budgets and staffs will be imperative for supplying even partially adequate service. However, given the necessary insight, training, determination and recognition of what is required, much can be done even under present limitations.

STANDARD NOMENCLATURE OF DISEASE

Many recent inquiries from hospitals and persons interested in disease classification have indicated that confusion has arisen in relation to the purposes of the new "Manual of International Classification of Diseases, Injuries, and the Causes of Death" and the "Standard Nomenclature of Disease." These books serve two distinct purposes, which do not overlap or conflict. The International statistical classification is published under the auspices of the World Health Organization. The main purpose of this classification is to establish international standards for coding diseases and carrying out large scale statistical studies. The diagnostic breakdown is much less specific than that of the "Standard Nomenclature of Disease." "The Standard Nomenclature of Disease and Standard Nomenclature of Operations" is published for the American Medical Association. This book standardizes and codes individual specific diagnoses designed for hospital filing and reference work. The diagnostic breakdown in the "Standard Nomenclature" is much greater than that of the International classification. At present the "Standard Nomenclature of Disease and Standard Nomenclature of Operations" is undergoing revision, and it is expected that the new volume will be published early in 1950. The new volume will also contain code numbers of the "International Classification" (parenthetically) for cross reference use in statistical studies.

9. Stellar, E., and McElroy, W. D.: Science, **108**: 281, 1948.

1. Psychiatric Needs in Rehabilitation: A Study by the New York City Committee on Mental Hygiene of the State Charities Aid Association, New York, 1948.

ORGANIZATION SECTION

Proceedings of the St. Louis Interim Session

MINUTES OF THE INTERIM SESSION OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION, HELD IN ST. LOUIS, NOVEMBER 30-DECEMBER 1, 1948

HOUSE OF DELEGATES

Second Meeting—Wednesday Afternoon December 1

The House of Delegates was called to order at 1:30 p. m. by the Speaker, Dr. F. F. Borzell.

Report of Reference Committee on Credentials

Dr. H. B. Everett, Chairman, stated that 173 delegates had been seated and that a quorum was present, and the Speaker announced that the House would proceed with its business.

Presentation of Minutes

It was moved by Dr. John W. Cline, California, seconded by several and carried, that the adoption of the minutes be deferred.

Executive Session—Wednesday Afternoon

On motion of Dr. Mather Pfeiffenberger, Illinois, regularly seconded and carried, the House went into Executive Session at 1:35 p. m.

Report of Reference Committee on Executive Session

Dr. J. Stanley Kenney, Chairman, presented the following report, which was adopted:

Your reference committee has given careful consideration to the following Resolution on Voluntary Participation in Government Plans introduced by Dr. Samuel J. McClendon, California:

WHEREAS, compulsory governmental medical insurance would (1) lower the quality of medical care, (2) substantially increase its cost, (3) create an administrative political bureaucracy, (4) weaken personal responsibility, (5) weaken local public responsibility, (6) fail to satisfy the demands for better medical care at lower cost, (7) waste and demoralize professional personnel, (8) fail to improve the quality or increase the number of professional personnel, (9) destroy voluntary plans for the provision of medical care, (10) most certainly ruin the most efficient, effective, progressive and sound system of medical practice—the American private practice of medicine—yet devised in the history of mankind; and

WHEREAS, The enactment of compulsory governmental medical insurance legislation is favored by the political party currently in power in the executive and legislative branches of the federal government of the United States of America; and

WHEREAS, Enactment of compulsory governmental medical insurance legislation by the 81st Congress of the United States of America may be imminent; and

WHEREAS, The Constitution of the United States of America guarantees the right of any physician to eschew personal participation in any scheme of compulsory governmental medical insurance; and

WHEREAS, All physicians are morally and professionally bound to hold the welfare of the patient paramount to all other consideration; and

WHEREAS, Compulsory governmental medical insurance is not consistent with the best interests of the patient; and

WHEREAS, Compulsory governmental medical insurance is the keystone of the arch of state socialism; be it then solemnly

Resolved, (1) That voluntary participation in any form of compulsory governmental medical insurance by any member of the American Medical Association shall be deemed an act unworthy of the noble heritage of our profession, an act against the concepts of individual freedom, personal responsibility and free enterprise, an act against the best interest of the patient and an act deserving of the strongest condemnation and censure by the American Medical Association and its membership;

(2) That personal honor, integrity and moral considerations render it impossible for any physician to participate voluntarily in compulsory governmental medical insurance; and

(3) That this House of Delegates make a statement of policy to all members of the American Medical Association with a request that written endorsement of this policy be obtained for all individual members of the medical profession.

No one appeared to discuss this resolution and it is the unanimous opinion of your reference committee that this resolution be disapproved.

Respectfully submitted,

J. STANLEY KENNEY, Chairman.
JESSE D. HAMER.
CLAUDE R. KEYPORT.
ERLING W. HANSEN.
WALTER G. PHIPPEN.

On motion of Dr. Kenney, seconded by several and carried, the report of the reference committee was adopted as a whole.

Wednesday Afternoon—Continued

On motion of Dr. H. P. Ramsey, District of Columbia, seconded by several and carried, the House rose from Executive Session at 1:40 p. m., to meet immediately in general session, Dr. F. F. Borzell, Speaker, presiding.

Report of Reference Committee on Amendments to the Constitution and By-Laws

Dr. Floyd S. Winslow, Chairman, presented the following report, which was adopted on motion of Dr. Winslow, duly seconded and carried after the Speaker declared that its adoption constituted an amendment to the By-Laws:

Your committee has carefully considered the three resolutions presented regarding changes in the Constitution and By-Laws concerning the Executive Session.

After hearing all sides of the question, your committee recommends the adoption of the report presented by the delegation from Pennsylvania, amended so that Division Three, Chapter IX, Sec. 3 (4) shall read: "The House of Delegates, in any session, by a two-thirds vote, may extend an invitation to address the House of Delegates to any individual who, in its judgment, might assist in its deliberation."

Respectfully submitted,

FLOYD S. WINSLOW, Chairman.
JAMES P. WALL.
VAL H. FUCHS.
DONALD CASS.

Report of Reference Committee on Reports of Board of Trustees and Secretary

Dr. Creighton Barker, Chairman, presented the following report, which was adopted section by section and as a whole, on motions of Dr. Barker, duly seconded and carried:

REPORT OF THE SECRETARY

The reference committee views with satisfaction the statement in the Report of the Secretary concerning the increase in membership in the Association. During the past nine months this increase has been substantial—2,053 Fellows and 4,258 members.

The reference committee also notes, and wishes to emphasize to the House of Delegates, the increased field activity of the Secretary, and, although it realizes the time and effort that these field trips take, it is confident that these visits bring the membership of the constituent associations much closer to Association headquarters.

All matters placed before the House of Delegates at its annual session in June have been referred to the proper agencies as directed by the House.

The committee wishes to compliment Dr. Lull on the active and vigorous conduct of the Office of Secretary and General Manager.

REPORT OF THE BOARD OF TRUSTEES

1. Finances: The reference committee wishes to direct the attention of the House to the financial statement of the Association and increased cost of the Association's operations. It is certain that these costs will increase, and your reference committee hopes that the House in this session will take appropriate action to provide generous financial support for the projects in which the Association is now engaged and for additional activities.

2. THE JOURNAL and Other Publications: All of the publications of the Association have prospered and extended their usefulness. THE JOURNAL continues to be the outstanding medical periodical in the world and HYGEIA the most important agency of lay information in matters of health. The circulation of HYGEIA is now 225,000 copies a month, nearly double that of three years ago.

The reference committee is in full agreement with that section of the report on THE JOURNAL which suggests a special publication to be devoted largely to the social, economic and industrial aspects of medicine, and your committee hopes that this may be established without delay.

3. World Medical Association: American medicine has a grave responsibility in the continued development of the World Medical Association; our participation in it is imperative to its success.

There is confusion in the minds of many concerning the World Medical Association and the World Health Organization. The World Health Organization is an official assembly of governmental agencies and is the health section of the United Nations. The World Medical Association is a voluntary association of representatives of medical organizations throughout the world. It has a great potential in bringing physicians from everywhere together and affords opportunity for discussion of mutual problems and development of mutual strength.

The reference committee wishes to encourage the Board of Trustees in this project.

4. The Mission to Japan: The reference committee wishes to call particular attention to the important mission to Japan carried out by five members of the Board of Trustees at the request of General MacArthur. It is a significant evidence of the esteem in which American medicine is held.

5. National Health Assembly: The reference committee wishes to commend the Board of Trustees for the action taken in relation to the National Health Assembly held in May, providing the opportunity for many informed spokesmen for American Medicine to present our views to the Assembly even though they were finally distorted and/or disregarded in the official reports.

6. Actions of House at June Session: The House of Delegates during its session in June took action on the service of physicians in connection with the draft and on several phases of the operation of the Veterans Administration. These matters are discussed in the report of the Board of Trustees, but no comment will be made on them by your reference committee, since resolutions relating to them are now pending before this House.

7. Reports of Councils and Bureaus of Board: The committee has reviewed the reports of all the bureaus and councils and the laboratory, and it is pleased to state that in its opinion, they are operating efficiently and being of great service.

8. Bureau of Legal Medicine and Legislation and Bureau of Medical Economic Research: Particularly does the committee mention the broad usefulness of the Bureau of Legal Medicine and Legislation and the Bureau of Medical Economic Research. The former has long been an active agency of the Association, and your committee is pleased to see that it continues as such and extends its services. The Bureau of Medical Economic Research is a new enterprise of the Association and has already taken its place as a valuable and unique stimulation to the better understanding of medical economic problems. It is hoped that its publications may have wider distribution among the profession and the public.

9. Board of Trustees: Your committee wishes to express appreciation to the Board of Trustees for its painstaking and time-consuming service to medicine in America, not only for the things embodied in the report presented to this House but also the myriad details which constantly confront it.

SUPPLEMENTARY REPORT OF BOARD OF TRUSTEES

1. Committee on Hospitals and the Practice of Medicine: The Board of Trustees also submitted a supplementary report which was a progress report of the Committee on Hospitals and the Practice of Medicine, under the chairmanship of Dr. Elmer Hess. That committee is charged with the analysis of a delicate question, and your reference committee will not comment at length on its preliminary report. It does, however, wish to urge on the committee the realization that although many of the problems involved must be settled at the local level, the American Medical Association, although it has no actual police power, must establish policies for the guidance of the component societies in all matters related to the practice of medicine.

2. The Future of Medicine in the United States: The reference committee took no action on a supplementary report from the Board of Trustees entitled, "The Future of Medicine in the United States." This report had to do with levying an assessment on constituent associations to finance additional activities of the American Medical Association. The report was referred to the Reference Committee on Legislation and Public Relations, which had received a number of other resolutions dealing with the same subject.

APPRECIATION

And now, Mr. Speaker, I wish to thank my colleagues on the committee for their assistance and those who appeared before the committee for the aid and guidance that we received from them.

Respectfully submitted,

CREIGHTON BARKER, Chairman.
SAMUEL J. MCCLENDON.
HANS H. F. REESE.
FRED H. MULLER.
COURSEN B. CONKLIN.

Report of Reference Committee on Sections and Section Work

Dr. Henry S. Ruth, Chairman, presented the following report, which, on motions of Dr. Ruth, duly seconded and carried, was adopted section by section and as a whole:

1. The Reference Committee on Sections and Section Work considered the two items referred to it, namely, the initial and supplementary reports of the Council on Scientific Assembly.

2. The Reference Committee commends and compliments the Council on the unique and well planned scientific program for the present Interim Session.

3. The appointment of officers for the forthcoming first meeting of the Section on Diseases of the Chest and a ruling for the election of their delegate and his alternate were approved, and these officers are welcomed to their new duties.

4. Identical action was voted in respect to the allotment of a session and the appointment of officers for allergy and two sessions for physical medicine in the Section on Miscellaneous Topics at the 1949 Scientific Assembly at Atlantic City, and your committee concurs in the encouragement for the possibility that a session be held once every second or third year on the history of medicine, as coinciding with previous indi-

cations that these portions of the report are consistent with the wishes of the House of Delegates.

5. The Reference Committee approves of the Council's correlation of the assignment of units of sessions for sections with past attendance at the recent section meetings. It took cognizance with praise of the accompanying table in the report showing attendance at recent section meetings. It is in accord with the Council's decision to accede to the wishes of the section secretaries in numbers of sessions granted as far as possible within the limitations of available physical space and other considerations, as well as the Council's objective toward stimulating by this recommendation the formation of continued vital and valuable programs. The committee was impressed with and expressed confidence in the Council's decision in adopting a fluid policy in respect to the number of sessions for each section.

6. The advisability of granting an increase in the membership of the Council from five to seven in number was clearly apparent for reasons adequately expressed; therefore, the Committee approves of such an enlargement and recommends that the indicated change in the By-Laws be presented at the next meeting of this House of Delegates for consideration at that time.

All the above recommendations were unanimously approved by your reference committee.

Respectfully submitted,

HENRY S. RUTH, Chairman.
THOMAS A. FOSTER.
BENJAMIN H. MINCHEW.
HOMER L. PEARSON.
JEAN P. PRATT.

Report of Reference Committee on Hygiene and Public Health

Dr. Stanley H. Osborn, Chairman, presented the following report, which was adopted section by section and as a whole on motions of Dr. Osborn, duly seconded and carried:

Your Reference Committee on Hygiene and Public Health had three matters referred to it for consideration on the following subjects: (1) Health Units for the Nation, (2) Diabetes Week and (3) The Proposed Definition of "Public Health."

1. Resolutions on Health Units for the Nation: These resolutions were introduced by Dr. Herbert P. Ramsey, District of Columbia, and, with minor changes, have the approval of your committee, to read as follows:

WHEREAS, No amount of medical care of persons already sick will substantially reduce the incidence of illness; and

WHEREAS, The traditional position of the American Medical Association has been one of firm support of public health services; in fact, this constitutes a major element of the Ten Point National Health Program of the American Medical Association; and

WHEREAS, Large numbers of local areas and counties in the United States are not now and never have been covered by adequate sanitary and other public health services; and

WHEREAS, The Surgeon General of the United States Public Health Service has announced that one of his first major objectives is assistance in development of local health units throughout the nation to meet this fundamental need; and

WHEREAS, The medical profession has now an opportunity to exert constructive leadership in this matter through the national, constituent state and component county medical societies; therefore be it

Resolved, That the House of Delegates reaffirm its abiding interest in the necessity for the provision of full time modern public health services at the local and community level, including sanitation and all the services usually considered essential for the preservation of the public health; and be it further

Resolved, That the United States Public Health Service be commended for, and encouraged in, its efforts for the further development of local health units for these purposes; and be it finally

Resolved, That the Board of Trustees be commended for its efforts in furthering full time local health units and urged to continue actively all proper procedures to the end that local public health service shall become adequate throughout the nation.

2. Resolutions on Support of Diabetes Week and Resolutions on Diabetes Week and Efforts in Behalf of the Undiscovered and Untreated Diabetic Patient: These resolutions on the subject of "Diabetes Week" have been referred to this committee, which approves these resolutions, with slight modifications, as follows:

WHEREAS, The medical profession has always recognized its obligations for the discovery, treatment and prevention of diabetes mellitus; and

WHEREAS, The number of persons with latent and undiscovered diabetes in the United States, according to surveys, is much larger than had been supposed and is estimated to be about 1,000,000 persons; and

WHEREAS, There exists also a large number of patients whose diabetes is neglected and who are therefore under ineffective or no treatment; and

WHEREAS, The American Diabetes Association, Inc., whose membership consists of more than a thousand doctors interested in diabetes, has appointed a committee to formulate plans for a national "Diabetes Week," December 6 to 12, 1948; and

WHEREAS, The purpose of this effort is to assist doctors and local committees in effectively carrying out continuing plans for discovering the unknown diabetic persons and guiding them to their physicians and for spreading widely to the public information about diabetes; and

WHEREAS, This is to be a doctor's project, of the profession, by the profession and for the public; and

WHEREAS, To achieve the aims of "Diabetes Week," the American Diabetes Association seeks to enlist the formal support and active cooperation of the medical profession through the American Medical Association and its constituent and component societies; therefore be it

Resolved, That the House of Delegates of the American Medical Association heartily endorse the efforts of the American Diabetes Association in behalf of the undiscovered and untreated diabetic person and approve of the plans for a "Diabetes Week" from December 6-12, 1948.

3. Proposed Definition of "Public Health" from the Report of the Council on Medical Service on Pages 125-126 of the Handbook: Your committee recommends that this definition be amended so that it will be in agreement with the Ten Point National Health Program of the American Medical Association. The following definition has the approval of your committee:

"Public Health" is the art and science of maintaining, protecting and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community and with the medically indigent.

Respectfully submitted,

STANLEY H. OSBORN, Chairman.
W. PALMER DEARING.
GERALD V. CAUGHLAN.
KARL S. J. HOHLEN.
ALBERT F. R. ANDRESEN.

Report of Reference Committee in Medical Education

Dr. James R. Reuling, Vice Speaker, assumed the Chair.

Dr. George W. Kosmak, Chairman, presented the following report:

REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

The report of the Council on Medical Education and Hospitals as published in the Handbook constitutes further evidence of the valuable work done by Dr. Herman G. Weiskotten and his associates in this important activity of the American Medical Association. Your reference committee, which has given diligent consideration to this report, desires to make the following comments, considering in their turn the various headings:

1. Financial Support of Medical Educations: This constitutes a topic of great importance to the medical profession. Decreasing income from former sources, increased costs of upkeep and administration, inflation and other factors constitute problems which have stimulated a search for funds from other sources, among them subsidies from the federal government. Naturally, the Council believes that this should be only a last resort and that further attempts should be made to secure the needed support from voluntary agencies. The Council believes that this can be developed through the medium of a national foundation for medical education and meetings have been held with interested lay groups to further the project. The Council believes that such support from voluntary sources in commerce, banking and industry is possible. Your reference committee feels that such activities should be continued and looks forward to the time when definite plans can be presented in future Council reports for action by the Association. It has no comments to offer.

2. Part Time Hospital Inspectors: Your committee commends the procedure adopted by the Council to make more adequate inspection of hospitals designated for intern and resi-

dent training in securing the assistance of part time inspectors for this purpose in various sections of the country. The more frequent appraisal of institutions appears essential to maintain adequate standards.

3. Resident Training and Development of Specialty Boards: In this connection attention might be drawn to the extension of the plan for resident training and the development of the "specialty boards." It is stated that at least one year of an approved rotating internship should be required before a physician can start his specialty training. Practically, this means that young physicians aspire to become residents in limited fields so that they may become eligible for examination by the various specialty boards and do not get enough training in general medicine to make good doctors of medicine. The tendency to specialize appears rather unfortunate in view of the universal desire for more general practitioners. How can this be obtained if we do not provide for the training of the latter and if we stimulate the development of more specialties by the methods now in vogue? In support of the activities of the House of Delegates of the American Medical Association in its attempt to redignify the general practitioner, your reference committee recommends that a reevaluation of basic teaching programs in undergraduate medical schools and of the overemphasis of specialty board certification be made by the Council on Medical Education and Hospitals.

4. Collaboration and Liaison with Other Agencies: The desirability of maintaining relations with other bodies interested in developing standards in teaching and other activities is acknowledged, and it is a satisfaction to note that cooperation is apparently universal. It is recommended, however, that the action of 1934 in refusing representation of two members of the Council on Medical Education and Hospitals as members of the Advisory Board for Medical Specialties be rescinded and that the American Medical Association request that two members of the Council on Medical Education and Hospitals be appointed on that Advisory Board instead of maintaining only the present liaison between the Council on Medical Education and Hospitals and the Advisory Board for Medical Specialties.

5. Summary of Hospitals and Technical Schools: It is of interest to be informed of the large number of institutions which have been under consideration by the Council. Such registration and approval should prove of enormous educational value, together with the regular publications of the Council in THE JOURNAL and elsewhere. Attention may be called to the statement that the hospitals approved for intern training call for 9,200 approved internships, whereas it has been stated in the report of a previous committee of this House that only 6,700 persons are available to fill these positions. Therefore, your reference committee believes that if a two year rotating internship could be arranged, the number would be definitely reduced.

6. Association of Interns and Medical Students and the Association of International Medical Students: Among other matters referred to the Council by the House of Delegates, your reference committee noted that the Council was requested to investigate the Association of Interns and Medical Students and the Association of International Medical Students as to facts, tendencies, affiliations and objectives. The Council has this under study, and your reference committee recommends that the matter be subjected to further investigation and that, if feasible, a report be submitted as soon as practicable.

7. Council Activities: To the Council have been assigned many problems in the field for which it was designated, and it has met these with understanding and knowledge. Its activities are therefore of paramount importance and value not only to the medical profession but to the community at large. Your reference committee is pleased to commend the Council highly for its outstanding accomplishments and desires to express gratitude and appreciation for its cooperation in the deliberations of this committee.

Your committee recommends the adoption of the report of the Council on Medical Education and Hospitals and in addition the adoption of the recommendations of the reference committee concerning several of the items in the report of the Council as mentioned.

SUPPLEMENTARY REPORT OF COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Your reference committee further recommends for approval the revised rules and regulations submitted by the Council on Medical Education and Hospitals in its supplementary report. This supplementary report included a revision of the Council's "Essentials of a Registered Hospital," "Essentials of an Approved Internship" and "Essentials for Approved Residencies and Fellowships." Your committee has suggested three minor alterations in these essentials; namely, in the "Essentials of an Approved Internship" on page 7 the wording "not less than twenty recognized medical journals" be changed to "an adequate number of recognized medical journals." In the Essentials of Approved Residencies and Fellowships" your reference committee recommends the omission of the paragraph on page 7 which reads: "Most residency programs are designed to meet the needs of physicians seeking certification by an American board. Therefore in fields represented by the American boards, the Council seeks to approve only such residencies or fellowships as will be acceptable in whole or in part for admission to the certification examinations." Your reference committee further recommends the deletion of the last paragraph on page 14 referring to the essentials for an approved residency in general practice which reads: "Since residencies of this type are planned to prepare the resident for general practice, they ordinarily do not carry credit towards certification by the specialty boards."

The suggested changes in these reports of the Council on Medical Education and Hospitals are offered for the sake of clarity and should not be interpreted in any way as detracting from the admiration that your reference committee has for the efficiency and excellence of the reports of the Council on Medical Education and Hospitals.

Your reference committee recommends the adoption of the essentials referred to with the modifications cited.

RESOLUTIONS

Resolution on Supplying Doctors for the Armed Forces: This resolution deals primarily with the deferment of medical students until completion of an internship not to exceed two years. Your committee believes that this matter should be given consideration by the Council on National Emergency Medical Service and respectfully suggests that it be referred to that Council.

Resolution on Increase in Number of Students Graduated at Medical Schools in Michigan: Your reference committee believes that the following resolution submitted by Dr. Wyman D. Barrett, Michigan, is based on false premises and is not inclined to give it consideration:

WHEREAS, There is general agreement as to the need for a larger number of physicians; and

WHEREAS, The facilities for teaching are not sufficiently increased to provide hope in the near future of answering the need for a larger number of physicians; and

WHEREAS, The number of individuals other than Doctors of Medicine licensed to practice the healing art in the State of Michigan has increased materially; therefore be it

Resolved, That the Michigan State Medical Society, through its officers, support any reasonable means to increase the number of students graduated from medical schools in this state, and that the delegates to the American Medical Association take similar action at the next meeting of the House of Delegates of the American Medical Association.

Resolutions on Interns: Your reference committee wishes to report that the matter contained in the following Resolutions on Interns submitted by Dr. Joseph F. Londrigan, New Jersey, is now under consideration by the Council on Medical Education and Hospitals and no further report is necessary:

WHEREAS, It is increasingly difficult for American Medical Association-approved hospitals to secure interns; and

WHEREAS, the Association of American Medical Colleges recommends reorganizing the plan of internship to give a two year service with the rotation so arranged as to make possible intensive training in the major divisions of medicine; therefore be it

Resolved, That the period or term of internship be extended to two years, one year rotating and the second year rotating or straight internship; and be it further

Resolved, That the specialty boards give credit for the second year of internship as the equivalent of a junior residency.

Resolution on Federal Subsidization of Medicine: The following Resolution on Federal Subsidization of Medicine has been referred to this reference committee, which believes that the resolution, including the original statement referred to in it, should be referred to the committee on legislation and public relations:

WHEREAS, the policy of the American Medical Association on federal subsidization of medicine has been clearly defined by its Council on Medical Education and Hospitals; and

WHEREAS, It is apparent from the recent action taken by an affiliated specialty academy that this policy is not being observed; be it

Resolved, that the American Medical Association, through its Council on Medical Education and Hospitals, reaffirm its statement on this matter and disseminate this statement to the responsible officials of all affiliated organizations and specialty groups.

Respectfully submitted,

GEORGE W. KOSMAK, Chairman.
MATHER PFEIFFENBERGER.
WILLIAM BATES.
LOUIS A. BUIE.
WARDE B. ALLAN.

The seven sections of the report of the reference committee dealing with the report of the Council on Medical Education and Hospitals were adopted section by section on motions of Dr. Kosmak, duly seconded and carried.

The report of the reference committee dealing with the Supplementary Report of the Council on Medical Education and Hospitals was adopted on motion of Dr. Kosmak, seconded and carried.

Dr. Kosmak moved adoption of the report of the reference committee referring to the Resolution on Supplying Doctors for the Armed Forces. The motion was seconded by Dr. Walter E. Vest, West Virginia, and discussed by Dr. Vest and by Dr. E. Vincent Askey, California, who moved an amendment that premedical students be considered in this problem as well as medical students, and the motion to amend was seconded by Dr. Vest, and carried. The motion to adopt this section of the report of the reference committee as amended was then carried.

It was moved by Dr. Kosmak, seconded and carried, that the report of the reference committee referring to the Resolution on Increase in Number of Students Graduated at Medical Schools in Michigan be adopted.

Dr. Kosmak moved adoption of the report of the reference committee dealing with the Resolutions on Federal Subsidization of Medical Education. The motion was severally seconded and discussed by Dr. Kosmak, who stated that he did not think the resolutions came within the province of this reference committee. Dr. Samuel J. McClendon, California, moved that the resolutions be acted on immediately, and this motion was duly seconded and carried after the resolutions had been reread.

Dr. T. K. Gruber, Michigan, moved that the resolutions be adopted, and the motion was seconded by Dr. Samuel J. McClendon, California. Dr. C. B. Conklin, District of Columbia, moved an amendment to the motion to strike out that part of the resolutions that refers to a certain academy, and the motion to amend was duly seconded and lost after discussion by Drs. C. B. Conklin, District of Columbia; Samuel J. McClendon and Robertson Ward, California; William D. Stovall, Wisconsin; H. P. Ramsey, District of Columbia; Louis A. Buie, Section on Gastro-Enterology and Proctology; Donald G. Anderson, Secretary of the Council on Medical Education and Hospitals; E. Vincent Askey, California; Morris Fishbein, Editor of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and James R. Reuling, Vice Speaker, and Dr. Kosmak.

The House then carried the motion to adopt the resolutions, which had been duly seconded, after discussion by Drs. E. Vincent Askey, California; Allen H. Bunce, Georgia; Samuel J. McClendon, California; E. H. Cary, Texas, and James R. Reuling, Vice Speaker, and Dr. Kosmak.

On motion of Dr. Kosmak, duly seconded and carried, the report of the reference committee as amended was adopted as a whole.

Report of Reference Committee on Reports of Officers

The Vice Speaker presided.

Dr. James Z. Appel, Chairman, presented the following report:

1. Address of the Speaker: (*a*) Your reference committee wishes to congratulate the Speaker in his efforts to expedite the business of the House of Delegates.

(*b*) Your committee believes, in observing this session, that a few changes might be made which would further facilitate this desire on the part of the Speaker. It would like to suggest that the roll call be so modified that all late comers quietly and while the House is conducting its business report their presence to the Secretary.

(*c*) Further, it believes that it is unnecessary and time consuming to count publicly the ballots of the vote for the General Practitioner's Award and the Distinguished Service Award.

(*d*) In this latter regard it recommends that the qualifications of the three nominees of the Board of Trustees for these two awards be mimeographed and those mimeographed copies be distributed to the Delegates at the time of the nomination. It does not believe that any other sketches of possible nominees should be permitted to be distributed.

(*e*) Your reference committee agrees with the Speaker that there should be some clarification in the By-Laws concerning the Executive Session. It understands that the implementation of this suggestion has been presented and is under consideration of another reference committee. It heartily endorses the idea.

2. Judicial Council: The report of the Judicial Council which appeared in the Handbook, pages 98 to 101 inclusively, met with the approval of your reference committee. It wishes to congratulate the Judicial Council on its expounding the principle that anesthesia is a medical service in contrast to its being a hospital service. It believes that this principle applies to the other specialties generally associated with hospital care as well. It regrets that the Judicial Council must again delay the formulation of a new Principles of Medical Ethics until the report of the Committee on Rebates has been acted on by the House. It can see the wisdom in doing so and can only hope that at the next session the Council will introduce a definite statement on this matter one way or the other. It is the opinion of your reference committee that effort should be made to instil in the members of the American Medical Association the knowledge and the practice of the Principles of Medical Ethics. It believes that the publication of a collection of questions and answers by the Judicial Council will be helpful in this matter. It urges the Judicial Council to take further steps to educate the young doctor and reeducate the older doctor of medicine in these medical ethics. As a suggestion it offers the idea of urging the county medical societies to institute indoctrination courses for all new members, which course would include a thorough understanding of the Principles of Medical Ethics.

Respectfully submitted,

JAMES Z. APPEL, Chairman.
J. B. LUKINS.
WILLIS I. LEWIS.
DEERING G. SMITH.
E. VINCENT ASKEY.

Dr. Appel moved adoption of the first paragraph of the report of the reference committee dealing with the Speaker's address, and the motion was seconded. There was discussion by Dr. F. F. Borzell, Speaker; Dr. Appel; Dr. James R. Reuling, Vice Speaker; Dr. G. Henry Mundt, Illinois; Dr. E. Vincent Askey, California, and Dr. E. L. Henderson, Chairman, Board of Trustees, after which Dr. Appel requested deletion of the part of the report referring to having mimeographed copies of qualifications of three nominees for Distinguished Service Award and General Practitioner's Award distributed to members of the House at the time that action is to be taken.

Dr. Appel then moved adoption of the report of the reference committee dealing with the first two paragraphs of the Speaker's Address. The motion was seconded and carried.

Dr. Appel moved adoption of the report of the reference committee contained in the third paragraph dealing with the Report

of the Speaker excluding the part deleted. The motion was duly seconded and discussed by Dr. R. W. Fouts, Vice-President; the Speaker; the Vice Speaker; Dr. Appel; Dr. G. Henry Mundt, Illinois, and Dr. Thomas M. D'Angelo, New York, who moved that the matter be tabled. The motion was regularly seconded and carried.

It was moved by Dr. Appel, duly seconded and carried, that the portion of the report of the reference committee referring to supplying mimeographed copies of qualifications of nominees for the awards be withdawn.

Dr. Appel moved, and the motion was seconded and carried, that the report of the reference committee dealing with the Report of the Judicial Council be adopted.

On motion of Dr. Appel, regularly seconded and carried, the report of the reference committee with the exception of that part that was deleted and tabled was adopted as a whole.

Report of Reference Committee on Emergency Medical Service

The Speaker resumed the chair.

Dr. Thomas F. Thornton, Chairman, presented the following report, which, on motions of Dr. Thornton, duly seconded and carried was adopted section by section and as a whole:

The deliberations of your reference committee were carried on with the aid and advice of the delegates from the Army, the Navy and the Public Health Service and of members of the Council on National Emergency Medical Service. The reports of this Council show a vigorous and continuing activity since the last meeting of the House of Delegates. Your committee feels that this Council should be commended on its fine work in dealing with this urgent problem relating to the use of physicians in our armed forces.

1. Report of Council on National Emergency Medical Service: The Report of the Council on National Emergency Medical Service, printed on pages 70 and 71 in the Handbook, was considered carefully. The committee particularly commends the Council for its emphasis on the need for economy in the use of physicians in the armed forces and for its concern in trying to keep civilian medical personnel adequate for civilian and industrial needs.

2. Statement of Council on National Emergency Medical Service: A statement of the Council on National Emergency Medical Service as printed in THE JOURNAL of the American Medical Association on Nov. 20, 1948, page 893, was next considered. The following resolution that was recommended by the council in that statement is recommended by this committee for adoption by the House of Delegates:

Be it Resolved, That in the light of current medical personnel shortages, and in line with the accepted policy for coordination by the armed forces, every effort should be made to consolidate the facilities for the hospital care of the several armed forces; and

Resolved, That the patient load in military hospitals, particularly of nonmilitary patients, be reduced to the minimum consistent with the primary mission of the armed forces as defined by Congressional Acts.

3. Resolutions on Position of Surgeons General: The committee next considered resolutions introduced by Dr. James C. Sargent, Wisconsin, in regard to the position of the Surgeon General of the Army, the Surgeon General of the Navy and the Air Surgeon. After discussion of the resolutions and the problems involved by the committee and others in attendance the committee recommends to the House of Delegates for its adoption the following substitute resolution:

WHEREAS, The chief medical officers of the Army, Navy and Air Force have a great responsibility in connection with the prevention as well as the treatment of diseases and injuries in members of the armed forces, and the modern unconventional weapons of war have serious medical and health implications both in defense and offense; and

WHEREAS, The effective execution of the medical mission in peace as well as in war demands that the chief medical officer in the three respective services have a voice in the planning and other activities affecting the health and the treatment of the sick and injured; and

WHEREAS, The Surgeon General of the Army and the Air Surgeon do not have comparable organizational relationship with their respective Secretaries and Chiefs of Staff as is enjoyed by the Surgeon General of the Navy with the Secretary of the Navy and Chief of Naval Operations; therefore be it

Resolved, That in peace as well as in time of war the Surgeon General of the Army and the Air Surgeon be so placed in the respective organizational set-up of the Army and the Air Force that he is directly under the Chief of Staff of the Army or the Chief of Staff of the Air Force, as the case may be; and be it further

Resolved, That the Surgeon General of the Army and the Air Surgeon have the responsibility directly under the Chief of Staff of the Army and the Chief of Staff of the Air Force respectively in all matters pertaining to health, hospitalization, evacuation, sanitation and research in their respective services; and be it further

Resolved, That a copy of these resolutions be sent to the President of the United States, the Secretaries of National Defense—Army, Navy and Air—and the members of the Committee on Armed Services of both the Senate and the House of Representatives.

4. Recommendation of Appointment of Civilian Medical Advisory Board: The Council on National Emergency Medical Service had recommended to the Secretary of Defense, Hon. James Forrestal, the appointment of a Civilian Medical Advisory Board to act in an advisory capacity with the Secretary of Defense on problems of the armed forces in the field of medicine. Dr. Sargent has received a telegram from the Secretary of Defense dated Nov. 29, 1948, reading as follows:

"Reference your telegrams of twenty four November Nineteen Forty-Eight concerning Medical Advisory Committee, on 9 November I approved a Charter for such committee, copies of which are in the hands of Admiral Boone. In addition, invitations for civilian membership have been issued to a number of eminent medical and allied professional individuals. Announcement of the formation and membership of this committee is being held up pending receipt of all acceptances to membership invitation. Greatly appreciate continued interest and support of you and the members of your Committee."

5. Armed Forces Medical Advisory Committee: Your reference committee also received a copy of the Charter issued by the Secretary of Defense, Hon. James Forrestal, establishing the "Armed Forces Medical Advisory Committee" and outlining the organization and functions of this committee. A copy of this charter is attached to this report.

6. Supplementary Report of Council on National Emergency Medical Service: The committee next considered the supplementary report of the Council on National Emergency Medical Service dated Nov. 29, 1948, introduced by Dr. E. L. Henderson, Chairman, Board of Trustees. This report includes four recommendations on policy. Your committee recommends adoption of the recommendations, to read as follows:

(*a*) It is recommended by the Council on National Emergency Medical Service to the House of Delegates that the American Medical Association favors the call-up and commissioning of the number of physicians in this age group already registered under the Selective Service Act of 1948 that are required by the armed forces to accomplish their primary mission of the defense of our country.

(*b*) The Council further recommends to the House of Delegates that it reaffirm its support of the democratic principles of our country and in so doing object to any special legislation which directly or indirectly singles out the medical profession for registration or draft in categories other than those established for their fellow citizens.

(*c*) It is further recommended that the House of Delegates of the American Medical Association authorize and urge the Council on National Emergency Medical Service, the officers and Trustees of the Association, as well as its constituent organizations operating through their committees on emergency medical service, to initiate and support a program for the recruitment of a sufficient number of qualified physicians for the armed forces.

(*d*) The Council on National Emergency Medical Service recommends to the House of Delegates that the resolution passed by it in June 1948 relative to the development of a resident training program in the Department of Army and the Department of Navy be clarified. Such a program represents the highest type of medical education but cannot be supported as a program of officer procurement beyond the peacetime needs of the agency to support its primary mission. Full utilization of civilian teachers and civilian clinical and hospital facilities for such a graduate training program of the armed forces or any other government agency is paramount to our national economy and the maintenance of the established high level of medical educational standards and training. Such a graduate training program for the armed forces or for any other government agency must be limited by the actual needs

of its peacetime establishment and the support of its primary mission as established by Congress. In our democratic form of government an adequate number of medical specialists always has been and always will be available to serve in the defense of our country.

Respectfully submitted,

THOMAS F. THORNTON, Chairman.
HOWARD B. GOODRICH, Acting Secretary.
F. S. CROCKETT.
W. A. COVENTRY.
JAMES BEEBE.

ADDENDA

THE SECRETARY OF DEFENSE
WASHINGTON

DIRECTIVE

Armed Forces Medical Advisory Committee: Pursuant to the authority vested in me by the National Security Act of 1947 (Public Law 253, 80th Congress), and in order to insure the highest possible standards of medical and allied professional care for personnel of the Armed Services and civilian employees thereof, there is hereby established, within the Office of the Secretary of Defense, an Armed Forces Medical Advisory Committee hereinafter called the Committee), with the composition and functions hereinafter described:

I. Composition of the Committee: The committee shall be composed of a civilian chairman designated by the Secretary of Defense, the Surgeon General of the Army, the Surgeon General of the Navy, the Air Surgeon, and not less than three other individuals who shall be appointed by the Secretary of Defense from among members of the civilian medical and allied professions.

II. Functions of the Committee: 1. The Committee shall serve in an advisory capacity to the Secretary of Defense on questions which affect the Armed Services as a whole in the fields of medicine and its allied professions. In these several fields, the committee shall, on request, or on its own initiative, submit recommendations to the Secretary of Defense with respect to (*a*) the establishment of general policies and programs for the National Military Establishment as a whole; (*b*) the development of medical and allied services capable of efficiently and effectively supporting the missions and needs of the Armed Services; (*c*) the elimination of unnecessary duplication or overlapping, and (*d*) the development of the maximum degree of continuing cooperation and mutual understanding between members of the civilian medical and allied professions and the Armed Services. The Committee shall concern itself with these matters not only as they relate to the Armed Forces in peacetime but also as they concern plans for mobilization in the event of any future national emergency.

2. The Committee shall, on request, render advice or assistance to the Secretary of the Army, the Secretary of the Navy, the Secretary of the Air Force, the Chairman of the Munitions Board, the Chairman of the Research and Development Board, or the head of any other board or agency in the National Military Establishment, with respect to any problems in the fields of medicine and allied professions which fall within the jurisdiction of his individual department or agency.

III. Administration: 1. The Committee, subject to the approval of the Secretary of Defense and the provisions of this directive, shall provide for its internal organization and shall establish its own rules and procedures.

2. The Committee is authorized to consult with such persons within the National Military Establishment as it may wish, to call upon any agency of the National Military Establishment for information and assistance which it may require, and to solicit the help of any other individuals or agencies, both governmental and non-governmental, whenever it deems this to be appropriate.

3. The Committee is authorized to establish such continuing or temporary subcommittees as may be necessary to conduct studies, assemble information, or otherwise carry out functions of the Committee. In doing so, full use should be made of any existing committee within the National Military Establishment.

4. The Secretary of Defense shall provide the Committee with such personnel, facilities and other administrative services as he from time to time determines are required for the performance of its functions.

Approved: 9 November 1948.

JAMES FORRESTAL.

Report of Reference Committee on Industrial Health

Dr. Thomas K. Gruber, Chairman, presented the following report, which on motions of Dr. Gruber, duly seconded and carried, was adopted section by section and as a whole:

1. Resolution on Accident Prevention: Your committee believes that this is a most noteworthy suggestion, and that the American Medical Association should be a leader in this most worth while effort, since accidents causing the death of 40,000 persons annually are in all probability preventable. Your committee approves this resolution.

2. Report of Council on Industrial Health: The report of the Council on Industrial Health, pages 67, 68 and 69 of the Handbook, is worthy of commendation, and evidences most worth while activity on the part of the Council.

(*a*) Annual Congress on Industrial Health: Your committee notes with interest that the next Annual Congress on Industrial Health, which will be held Jan. 18 and 19, 1949, will be a joint meeting with the Division of Industrial Hygiene of the United States Public Health Service and interested departments of the American Medical Association. It will include panels devoted to public relations, medical administration and environmental hygiene, medical hospital service, health education and preventive medicine.

Your committee believes that this House of Delegates should reaffirm past actions of this House of Delegates of the American Medical Association which expressed approval of industrial health planning by management, labor and medicine.

(*b*) Workmen's Compensation: Your committee approves the appointment of consultants to the Council on Industrial Health representing the administrative, legal, insurance and technical aspects of workmen's compensation.

(*c*) Civil Defense and Industry: Your committee is in accord with the action taken by the Council on Industrial Health recognizing the important part played by industrial workers in national defense, and approves the appointment of a committee to assist in the formulation of a proper program.

3. Supplementary Report to the Board of Trustees from the Council on Industrial Health on Medical Advisory Board of Welfare and Retirement Fund, United Mine Workers of America: Your committee compliments this supplementary report which deals with the pattern of procedure in the handling of hospital and medical care developed by the United Mine Workers Health and Welfare Retirement Fund. This report is noted with great interest.

Your committee particularly approves of the proposal made by the Medical Advisory Board of the United Mine Workers Health and Welfare Retirement Fund which calls for the creation of an advisory committee from each state medical society in each state in which the fund operates. These committees should be of great assistance to the regional officers in the development of policy and the promotion of proper administrative relationship.

Your committee approves the report of the Council on Industrial Health as well as the supplementary report and commends the Council for the work accomplished.

Respectfully submitted,

T. K. GRUBER, Chairman.
HOMER G. HAMER.
WILLIAM L. BENEDICT.
H. B. MULHOLLAND.

The House recessed at 3:15 p. m. and reconvened at 3:40 p. m., with the Speaker, Dr. F. F. Borzell, presiding.

Report of Reference Committee on Miscellaneous Business

Dr. Walter E. Vest, Chairman, presented the following report, which on motions of Dr. Vest, duly seconded and carried, was adopted section by section and as a whole, after an amendment to include a telegram was tabled:

1. Resolutions on Proposed Veterans Hospital Near Ann Arbor, Mich.: Your committee would reiterate the stand heretofore taken by the American Medical Association in which it explicitly expressed its objection to the utilization of veterans hospitals for non-service-connected disability cases, except for those patients who are medically indigent. It is the opinion of your committee that the present plans of the Veterans Administration will result in overbuilding, and it urges that before constructing other hospitals the medical society of the state in which the proposed hospital is to be constructed be consulted as to the actual need for the proposed hospital, pointing out that government funds are now available under the Hill-Burton Act to increase hospital facilities in local communities where such facilities are needed.

2. Report of Liaison Committee to Consider Red Cross Blood Bank Program: Your committee recommends acceptance of the report of the Special Liaison Committee to Consider Red Cross Blood Bank Program presented by Dr. L. W. Larson as a progress report. Your committee further recommends that this special committee be continued, with as little change in personnel as possible, and that it be instructed not only to act as a liaison committee with the American Red Cross Blood Program, but also to evaluate the private blood bank situation throughout the country and explore the possibilities of the development of further local blood banks in areas not now supplied with blood banks. It also recommends that this committee report the status of its studies and endeavors to each session of the House of Delegates.

3. Resolutions on Reorganization of Council on Medical Service: It is the opinion of your committee that the recommendations coming from the Chairman of the Council on Medical Service should be approved in toto. It recommends, therefore, the approval of the resolutions as presented.

4. Resolutions on Selective Service: Your committee believes that the premises on which the resolutions adopted by the House of Delegates in June 1948 were based were erroneous, and that the resolutions then adopted place the medical profession definitely in an unfavorable light. Your committee recommends, therefore, reconsideration of the action taken in June 1948 and approval of the resolutions.

5. Resolutions on Compulsory Hospital Staff Attendance: Your committee calls attention to the fact that the American Medical Association has not at any time advocated compulsory attendance at stated staff meetings. This committee is in sympathy with the philosophy prompting the resolutions.

6. Report of Committee on Rebates: Your committee has given prolonged consideration to this matter and approves that portion of the report which states that the House of Delegates reiterates condemnation of the practice of any member's accepting rebates, and that the House of Delegates condemns also the practice of giving rebates by a member. It urges that the different state societies in those states in which such practices are not now illegal give serious consideration to the introduction of legislation making the practice of rebating to or by physicians illegal.

Your committee recommends further to the component county societies that on the receipt of a bona fide complaint the disciplinary committee of that society hold a hearing and endeavor to make an investigation of the doctor's records and accounts at society expense, and that a record of such hearing and examination be kept for the information of the state society and, if necessary, for the Judicial Council of the American Medical Association.

Respectfully submitted,

Walter E. Vest, Chairman.
Herbert H. Bauckus.
Britton E. Pickett Sr.
James P. Kerby.
J. Wallace Hurff.

Report of Reference Committee on Legislation and Public Relations

Dr. Thomas K. Lewis, Chairman, presented a report stating that he requested that one section of the report of his committee be considered in Executive Session. The sections of the report submitted in open session were adopted on motions of Dr. Lewis, duly seconded and carried after amendment. This report, as amended, reads:

1. Report of the Executive Assistant: Your committee commends the excellent work of the Executive Assistant and feels that his accomplishments have more than justified the creation of this new office.

The committee wishes to call the attention of the House to the interest of other organizations in the Public Relations Conference held at this session. The committee is of the opinion that the American Medical Association should gratefully accept and commend the assistance of all organizations which have in the past, or may in the future, aid in efforts toward preservation and improvement of a high standard of medical care for the American people. The PR Doctor, the Secretary's Letter and other publications emanating from headquarters have been of inestimable value and will be enhanced and enlarged in the future under the new plan proposed by the Board of Trustees. The basic and most effective form of public relations is that which emanates from the doctor's office; therefore a wider dissemination of these publications is recommended. Your committee recommends the approval of that portion of the report of the Executive Assistant referred to it.

2. Report of the Council on Medical Service: (*a*) Your committee approves that portion of the report allocated to it on pages 115 to 118 of the Handbook. Your committee would comment on the tremendous public relations value of the Council's activities in fostering and stimulating community leadership. The regional conferences have been of exceptional value. Your committee would suggest that a larger attendance at these meetings should be encouraged.

(*b*) The Washington Office: Pages 126 to 128 of the Handbook. The Washington Office has become an increasingly important and effective agency. This Office should be expanded as rapidly as practicable.

Your committee approves those portions of the report of the Council on Medical Service.

3. Resolutions on Medical Service Plans: Your committee approves of these resolutions amended to read as follows:

Resolved, That the American Medical Association reiterate to the public its approval of these medical service plans and stress the desirability of their rapid expansion; and be it further

Resolved, That the American Medical Association urge, with moral support, every constituent state society to undertake the organization and operation of medical service plans, covering the services mentioned above, as expeditiously as possible; and be it further

Resolved, That the American Medical Association urge the rank and file of the profession to participate in and give whole-hearted support to the operation of these duly authorized and approved medical service plans; and be it further

Resolved, That the American Medical Association announce to the public the availability of such plans and give the widest possible publicity as to the purpose of and the benefits to be derived from nonprofit voluntary prepayment medical service plans.

4. Report of Committee on Veterans Affairs: Your committee recommends that the House of Delegates commend the efforts of the Committee on Veterans Affairs and recommends that the committee continue its negotiations with reference to this complex problem, holding as it has done in the past to the principles established by the House of Delegates with regard to the care of veterans who have established the fact of their inability to pay for needed medical services and hospitalization. It is suggested that this committee be directed to report to the House of Delegates in June of 1949 and that, in the meantime, it report periodically to the Board of Trustees concerning the progress of its efforts at negotiations in this matter.

5. Resolutions on Gathering and Dissemination of Information Relative to Health Legislation and Resolution on Presentation of Facts Concerning Health Care to Members of Congress: Resolutions from Kentucky and Oklahoma were introduced regarding activities along the line of contact with legislators. Your committee feels that the mechanism for the implementa-

tion of these recommendations is already in existence and, therefore, that no action need be taken on these resolutions. However, it feels obligated to call to the attention of the members of this House of Delegates the importance of taking home with them the obligation to see to it that their state and component county medical societies participate in the activation of a legislative program which, to be effective, must be on a local level.

Respectfully submitted,

THOMAS K. LEWIS, Chairman.
JOHN W. CLINE.
CHARLES H. PHIFER.
EDWARD H. CARY.
CLIFFORD C. SHERBURNE.

Closed Session

On motion of Dr. Clifford C. Sherburne, Ohio, regularly seconded and carried, the House resolved itself into Closed Session to hear the balance of the Report of the Reference Committee on Legislation and Public Relations, after a proposed amendment of Dr. H. P. Ramsey, District of Columbia, to have the Closed Session at the conclusion of all business, which was duly seconded, was lost.

The House entered into Closed Session at 4:20 p. m.

Report of Reference Committee on Legislation and Public Relations

Dr. Thomas K. Lewis, Chairman, presented the following report, which was adopted as amended, on motion of Dr. Lewis, duly seconded and carried after discussion:

Report of Board of Trustees on the Future of Medicine in the United States; Resolution on National Publicity; Resolutions on a Public Relations Program, and Resolutions on Compulsory Health Insurance: Four resolutions were presented to the committee for consideration coming from (1) the Board of Trustees, (2) Colorado, (3) California and (4) Michigan.

With regard to the Colorado resolution, your committee recommends that it be turned over to the newly appointed Planning Committee as a suggestion for guidance in outlining its activities. The other three resolutions on this subject were rather similar in content and, therefore, have been combined into one resolution, the framework of which is based on the resolutions introduced by the California Medical Association.

The resolutions as finally recommended and adopted by the House read:

Resolved, That this House of Delegates instruct the Board of Trustees to implement a "Statement of Policy" as adopted by the House at this session;

Resolved, That the House of Delegates declare that the Board of Trustees of the American Medical Association has its complete confidence in its intention and ability to carry out the objectives and execute the mandates of the House of Delegates;

Resolved, That the House of Delegates authorize the Board of Trustees to levy an assessment of $25 on the members of the American Medical Association;

Resolved, That this House of Delegates hereby directs the immediate expansion of the Washington Office and its placement directly under the supervision, direction and control of the Board of Trustees;

Resolved, That the immediate employment of suitable public relations counsel to assist in the execution of this program be recommended;

Resolved, That in order to coordinate the activities of the public relations phase of this program at all levels the public relations counsel shall disseminate information to (*a*) the general public, (*b*) the Congress of the United States and (*c*) state and county medical societies and individual physicians;

Resolved, That it be the unanimous expression of the medical profession, as represented by the House of Delegates, that we are firmly united behind the positive and constructive program as outlined by the House of Delegates; that we are confident in the ability of our leadership; that we are determined to protect and foster the high standards of medical care for the public; that we are steadfastly opposed to the regimentation and socialization of American medicine, and that we are confident that an intelligent and informed public will join us in our crusade to ever improve the health and welfare of the American people.

On motion of Dr. Philip W. Morgan, Chairman, Reference Committee on Rules and Order of Business, seconded and carried, the House rose from Closed Session at 4:55 p. m.

Wednesday Afternoon—Continued

The House reconvened in regular session at 4:55 p. m. with the Speaker, Dr. F. F. Borzell, presiding.

Dr. Philip W. Morgan, Chairman, Reference Committee on Rules and Order of Business, moved that the report of the Reference Committee on Medical Service and Prepayment Insurance Plans be heard and action taken without debate, since all interested parties appeared before the reference committee earlier in the day. The motion was regularly seconded and lost after discussion by Dr. John W. Cline, California.

Report of Reference Committee on Medical Service and Prepayment Insurance Plans

Dr. Raymond L. Zech, Chairman, presented the following report, which on motions of Dr. Zech, duly seconded and carried, was adopted section by section and as a whole:

1. Report of Council on Medical Service: That portion of the Report of the Council on Medical Service in the Handbook on pages 118 to 126 has been reviewed and approved with certain changes.

These changes occur on page 119, in which the last sentence has been deleted and the sentence before that in the third paragraph under "Compulsory Sickness Insurance" has been changed to read: "The Council believes that these should be placed in every college, medical school and hospital library and public libraries and in high school libraries on request."

2. Statement of Policy of American Medical Association: This statement submitted by Dr. E. Vincent Askey, representing the California Medical Association, relative to a statement of policy is approved wtih the following change in paragraph 1, line 4. This now reads, "Coverage is now provided throughout the country and protection is being extended rapidly to an ever increasing portion of our population." Your reference committee believes that this could be somewhat strengthened by changing that sentence to read: "Constantly increasing coverage is being provided throughout the country and protection extended to an ever increasing proportion of our population."

The second paragraph, beginning with the words, "compulsory sickness insurance," your committee believes could be improved by placing a period after the word "scheme," so that the second sentence from the bottom of that paragraph would then read: "The American Medical Association rejects any such scheme." deleting the semicolon and making a new sentence to read: "We are equally certain that when the people understand the facts they also will reject it with the same finality."

3. Resolution on Blue Cross-Blue Shield Proposals and Resolutions on National Health Insurance: The resolutions of the Michigan State Medical Society and the following resolutions, presented by Dr. C. C. Sherburne, Ohio, relative to the formation of a Blue Cross-Blue Shield Association and a Blue Cross-Blue Shield Health Service, Inc., were considered:

WHEREAS, The House of Delegates of the American Medical Association has already endorsed, at one of its previous sessions, the establishment of voluntary plans for the prepayment of medical care costs; and

WHEREAS, It has been the purpose of the medical profession, in establishing such plans, to extend their protection as rapidly as possible to all segments of the American public; and

WHEREAS, It has been difficult, if not impossible, to enrol certain large segments of the population because of a lack of correlated enrolment facilities on the part of the plans; and

WHEREAS, The need for establishing adequate facilities for the enrolment of national accounts has been recognized; and

WHEREAS, Specific proposals for establishing such facilities have been prepared and approved by the Blue Shield Commission of Associated Medical Care Plans, and at the request of its member plans; therefore be it

Resolved, That the House of Delegates of the American Medical Association approve the establishment of a Blue Cross-Blue Shield Association and a Blue Cross-Blue Shield Health Service, Incorporated, as contained within the published proposals referred to above.

In an open session lasting three hours, the committee heard arguments for and against the resolutions from Ohio and Michigan. The committee is in entire accord with the necessity and advisability of extending medical care and coverage to all classes of our population. Your committee does not believe that sufficient factual data have been supplied to enable it to make an intelligent decision on this most important subject. Therefore, these resolutions from Ohio and Michigan are not approved.

4. Resolution on Associated Medical Care Plans Incorporated: Your committee recommends disapproval of the Resolution on Associated Medical Care Plans Incorporated.

5. Supplementary Report of Council on Medical Service: The Supplementary Report of the Council on Medical Service relative to the A. M. C. P. proposal to form a national insurance company was carefully reviewed. Your reference committee recommends the adoption of the supplementary report with the following addition to paragraph 1, "further development of coordination of and reciprocity among the local plans."

Respectfully submitted,

RAYMOND L. ZECH, Chairman.
W. H. HALLEY.
J. F. LONDRIGAN.
H. E. GRIFFIN.
W. L. ESTES JR.
F. J. PINKERTON.
F. J. L. BLASINGAME.

Report of Board of Trustees

Dr. E. L. Henderson, Chairman, presented the following report:

1. Planning Committee: Mr. Speaker and Members of the House of Delegates: Yesterday, when I announced to you that the Board of Trustees had formed the Planning Committee, I told you that we would submit the name of that committee to you today. We have decided on the name "Coordinating Committee for the Protection of the People's Health." I wish to announce that that committee will have its first meeting tomorrow morning at ten o'clock in Room C, where the Board of Trustees has been meeting.

If any member of the House knows of any organization interested in this great principle of protecting the American Way of Life that will join with the profession, will he please submit the name of that organization to this committee?

2. Interim Session in 1949: At the June meeting of the House of Delegates, I announced that the next Interim Session would be in Tampa, Fla. I wish to tell you at this time that the Board of Trustees has rescinded that and will announce a little later where that session will be held. It was thought by the Board of Trustees that that session should be more centrally located than Tampa.

Resolution on Expression of Appreciation

Dr. James C. Sargent, Wisconsin, asked the unanimous consent of the House to present for adoption without reference to a committee a Resolution on Expression of Appreciation.

Receiving unanimous consent, Dr. Sargent presented the following resolution, which was adopted on motion of Dr. Sargent, duly seconded and carried:

WHEREAS, The physicians of America have a deep concern over the medical and health care prevailing within the military establishment and in the civilian population of the country in time of national emergency; and

WHEREAS, The medical profession of America represented by the American Medical Association feels a deep sense of appreciation for the consideration and understanding with which its recommendations concerning the general structure of the National Defense Establishment have been received; therefore be it

Resolved, By the House of Delegates of the American Medical Association that a proper expression of its appreciation be extended to the President of the United States, the Secretary of Defense and the Chairman of the National Security Resources Board by the President of the American Medical Association.

Remarks of Speaker

The Vice Speaker took the Chair.

Dr. F. F. Borzell, Speaker, thanked the members of the House for their cooperation and suggested that hereafter the delegates refrain from stating that resolutions were approved by this, that and the other state, permitting each state to present its own resolution.

He also expressed regret that Dr. Walter F. Donaldson, Pennsylvania, who had served as delegate for more than twenty-five years, was leaving the House at this session, after which the House rose in honor of Dr. Donaldson.

On motion of Dr. John W. Cline, California, duly seconded and carried, the House adjourned sine die at 5:10 p. m.

Washington Letter

(From a Special Correspondent)

Dec. 13, 1948.

Scottish Under-Secretary of Health Visiting United States

T. D. Haddow, Under-Secretary of Health for Scotland, who is visiting the United States as a Commonwealth Fund fellow, will spend the greater part of January in California, he asserted shortly before leaving Washington to inspect the Federal Communicable Disease Center in Atlanta, Ga. On the West Coast he will study state and local public health activities and facilities. Mr. Haddow left Scotland in September, which, he said, was too soon after launching of the British health service program to enable him to draw any conclusions on efficiency of its operation. He volunteered, however, that fears of the Scottish Department of Health that there would be a large volume of complaints by patients in the first few weeks did not materialize. Mr. Haddow added that dissatisfaction was expressed by some participating physicians because payments for services rendered were not as large as they had been given to believe.

Veterans Administration Reports on "Home Town" Medical Care in 1948

An annual report just released by Veterans Administration reveals that during the fiscal year ended June 30, 1948, private physicians treated 761,165 veterans under arrangements with the Veterans Administration. For their services they received $11,437,739 for a total of 2,735,429 treatments. Thus, the average cost per treatment was $4.18 and the cost per veteran, for the twelve month period, was $15.03. In the same period, Veterans Administration staff doctors at outpatient clinics administered 1,680,183 treatments to 865,004 veterans. For the first quarter of the present fiscal year (July, August and September 1948), the number of cases handled—both by private physicians and Veterans Administration staff men—ran about 30 per cent behind the figure for the corresponding period in 1947.

Navy's Second Course for Medical Reservists

Gratified by the success of its special five day course in "Medical Aspects of Special Weapons and Radioactive Isotopes," which ended December 10, the Bureau of Medicine and Surgery has announced that a second course will be conducted in mid-February. It will be five and one-half days in length—a half-day longer than the December seminar—and will offer some curricular changes. It is due to open February 14, with two hundred and ten vacancies for members of the Navy Medical Corps Reserve. The December session had approximately one hundred and fifty in attendance. Applications should be directed to commandants of the respective naval districts before Jan. 17, 1949. The February course, like its predecessor, will be held at the Naval Medical School, Bethesda, Md.

Coming Medical Meetings

Annual Congress on Industrial Health, Chicago, Drake Hotel, Jan. 18-19. Dr. Carl M. Peterson, 535 N. Dearborn St., Chicago 10, Secretary.

Annual Congress on Medical Education and Licensure, Chicago, Palmer House, Feb. 7-9. Dr. Donald G. Anderson, 535 N. Dearborn St., Chicago 10, Secretary.

National Conference on Rural Health, Chicago, Palmer House, Feb. 4-5. Dr. F. S. Crockett, 535 N. Dearborn St., Chicago 10, Chairman.

American Society for Surgery of the Hand, Chicago, Jan. 21-22. Dr. Joseph H. Boyes, 1401 S. Hope St., Los Angeles 15, Secretary.

International Post-Graduate Medical Assembly of Southwest Texas, San Antonio, Jan. 23-27. Dr. John J. Hinchey, P. O. Box 2445, San Antonio, Secretary.

Southeastern Allergy Association, Durham, N. C., Washington-Duke Hotel, Jan. 22-23. Dr. Katharine B. MacInnis, 1515 Bull St., Columbia, S. C., Secretary.

Southeastern Surgical Congress, Biloxi, Miss., Jan. 24-27. Dr. Benjamin T. Beasley, 45 Edgewood Ave. S.E., Atlanta 3, Ga., Secretary.

Western Section American Urological Association, Coronado, Calif., Hotel del Coronado, Jan. 17-19. Dr. Adolph A. Kutzmann, 1930 Wilshire Blvd., Los Angeles 5, Secretary.

GOVERNMENT SERVICES

ARMY

CONSULTANTS TO THE PACIFIC AREA IN 1948

The Surgeon General's Office has been carrying out a program designed to bring to the Army Medical Department in the Pacific Area the latest advances in the field of medicine and in so doing assigned during 1948 the following civilian consultants to aid in this work:

Name	Residence	Specialty
MARCH		
Coley, Milton C.	Washington, D. C.	Orthopedics
Horgan, Edmund	Winchester, Va.	Surgery
Overstreet, Sam A.	Louisville, Ky.	Medicine
APRIL		
Bauer, Frank, Lt. Col.	Washington, D. C.	Medicine
Colonna, Paul C.	Philadelphia	Orthopedics
Mustard, Russell L.	Battle Creek, Mich.	Surgery
Walson, C. M., Brig. Gen.	Great Neck, N. Y.	Adm. Specialist
MAY		
Blankenhorn, M. A.	Cincinnati,	Medicine
Currier, W. D.	Pasadena, Calif.	Ear, Nose & Throat
Webster, James R.	Chicago	Dermatology & Syphilology
JUNE		
Bannick, Edwin G.	Seattle	Medicine
Barnard, Leonard	Oakland, Calif.	Orthopedics
Joyner, E. N., III	New York	Pediatrics
Williamson, Edwin M.	Kalamazoo, Mich.	Neuropsychiatry
JULY		
Cotton, John M.	New York	Neuropsychiatry
Griffith, George C.	Pasadena, Calif.	Medicine
Koontz, Amos	Baltimore	Surgery
Price, Carleton N.	Washington, D. C.	Obstetrics & Gynecology
Snyder, Clarence H.	Grand Rapids, Mich.	Orthopedics
AUGUST		
Bailey, Percival	Chicago	Neuropsychiatry
Baker, Lenox D.	Durham, N. C.	Orthopedics
Helwig, Ferdinand C.	Kansas City, Mo.	Pathologist
Speir, Edward B.	Seattle	Surgery
SEPTEMBER		
Compere, Edward L.	Chicago	Orthopedics
Sanger, Paul W.	Charlotte, N. C.	Surgery
OCTOBER		
Furstenberg, A. C.	Ann Arbor, Mich.	Ear, Nose & Throat
Hayman, J. M.	Cleveland	Medicine
Smyth, Francis Scott	San Francisco	Pediatrics
Waggoner, Raymond W.	Ann Arbor, Mich.	Neuropsychiatry
White, J. Warren	Greenville, S. C.	Orthopedics
NOVEMBER		
Kendell, H. Worley	Chicago	Medicine
Kerr, William J.	San Francisco	Medicine
Moore, John R.	Mobile, Ala.	Orthopedics

MILITARY RESIDENT TRAINING

Regular Army commissions, in the grades of first lieutenant and captain, have been awarded to eighteen physicians preparatory to their entering the first year of military residency training in their various professional specialties next January.

Major General Raymond W. Bliss, the Surgeon General of the Army, announced that five Army teaching hospitals—Letterman General Hospital, San Francisco; Brooke General Hospital, Fort Sam Houston, Texas; Oliver General Hospital, Augusta, Ga.; Fitzsimons General Hospital, Denver, and Walter Reed General Hospital, Washington, D. C.—are providing instruction at the levels of assistant resident, resident and senior resident in ophthalmology, internal medicine, general surgery, pathology, orthopedics, psychiatry, otolaryngology, radiology, urology and other specialties.

This training as part of the recently evolved Graduate Professional Training Program is designed to offer all qualified applicants the opportunity to meet their requirements for certification by an American specialty board in the fields of their choice, contingent on the needs of the Army.

Applications for the next phase of the training program, to begin next July 1, are being received by the Office of The Surgeon General. No action will be taken on these until physicians applying have accepted commissions in the Regular Army.

The eighteen newly commissioned officers who will enter the program in January are: Herbert M. Alston, Columbus, Texas; John H. Bickerton Jr., Los Angeles; Ernest M. Bralley Jr., New York; James N. Brien Jr., Memphis, Tenn.; Samuel J. Camarata, Pittsburgh; Layne E. Carson, Wynne, Ark.; Francis E. Foley, New York; Harry M. Henderson, Fort Sam Houston, Texas; Augustus B. Jones Jr., San Francisco; Oliver Mays, Austin, Texas; Clarence S. Miller, San Francisco; William Moore, Fort Sam Houston, Texas; Marvin E. Perkins, Fort Eustis, Va.; Thomas F. Puckett Jr., 7th Infantry Division; Herbert P. Sube, Madigan General; Leo S. Szakalun, Wilmington, Del.; Donald R. Taylor, 1106th A.S.U. Medical Detachment, and George S. White, Ridgely, Md.

RESEARCH ON JAPANESE ENCEPHALITIS

The Surgeon General announces that plans have been made for a new study of the carriers of Japanese encephalitis and host reservoirs of this disease in Okinawa and Japan. This study will be made on a large scale, particularly in view of the recent epidemic of encephalitis among the natives, which carried a high mortality rate. Basic material for the study is provided in a recent publication entitled "Mosquito Fauna of Japan and Korea," by Major Walter J. La Casse, an entomologist of the Army Medical Service Corps. This report represents a study of the countless breeding places for mosquitoes in rice paddies, decorative pools in sacred gardens, moats, water-filled depressions in bombed areas, and other places. For years the Army Medical Research and Graduate School has been engaged in research to find a successful treatment of this disease, chiefly by means of a vaccine. Colonel Thomas E. Patton Jr., Deputy Chief, Preventive Medicine Division, the Surgeon General's Office, is hopeful that by close cooperation with allied scientists and civilian consultants a method of controlling Japanese encephalitis will be found.

BIOLOGISTS, ENTOMOLOGISTS AND MYCOLOGISTS WANTED

The Board of U. S. Civil Service Examiners, Army Chemical Center, Md., announces that opportunities are available for the employment at that location under civil service of biologists (medical), entomologists (research) and mycologists (research) for probational appointment. For details write to the Board of U. S. Civil Service Examiners, Army Chemical Center, Md.

MONTHLY MEDICAL MEETING

At the regular monthly medical meeting conducted by The Surgeon General at the Walter Reed Hospital, Washington, D. C., on December 16, Dr. Howard B. Lewis will speak on "Protein Metabolism in Disease" and Dr. J. W. Conn on "Endocrinology and Metabolic Diseases." Both speakers are from the University of Michigan Medical School, Ann Arbor.

ARMY MEDICAL LIBRARY

The increase in Japanese publications received by the Army Medical Library has necessitated organizing an extra team of catalogers in the Index-Catalogue Division to handle Japanese publications published without romanized abstracts.

The Army Medical Library now holds 85 per cent of the important German medical books published during the war

years, practically all of which were obtained through the Library of Congress Cooperative Acquisitions Project. The library will attempt to acquire the other 15 per cent.

The library has received films of 252 manuscript theses submitted to the University of Paris for the year 1939; films of several thousand theses submitted in manuscript form from 1943 to 1948 will be received, and thus complete the library's collection of Paris theses. Copies of these films can be supplied to other libraries from the negatives in the Army Medical Library.

RESEARCH ON MELANOMA

The Surgeon General announces that the Army will make an intensive study of some 400 autopsy and surgical specimens of melanoma at the Army Institute of Pathology. Thousands of slides for an exhaustive study of this subject will be prepared, in order, if possible, to bring about a complete histologic understanding of this disease, its manner of growth and criteria for recognition. To cover the Army's broad field of dermatology, twenty-seven additional specialists are needed in the Army Medical Department—seven dermatologists who are certified specialists and twenty who have completed dermatology residencies. Information regarding these openings may be obtained by writing The Surgeon General of the Army, Washington 25, D. C.

PERSONAL

Colonel Charles H. Beasley, Retired, has received the military award of the Order of Leopold from Belgium for outstanding services during the time that he served as Surgeon of the Advanced Section of the Communications Zone with headquarters at Namur from Oct. 25, 1944 to April 7, 1945. During this period Colonel Beasley established and directed twenty-five hospitals in Belgium which handled more than 1,000,000 casualties.

NAVY

FIRST ACTIVE DUTY AS INTERNS

The following lieutenants (jg) with the medical corps reserve have received orders for their first active duty as interns in the institutions indicated: John S. Anderson, Salina, Kan., to City Hospital of Akron, Ohio; Markham J. Anderson, St. Paul, Minn., to a fellowship in surgery at the Mayo Foundation, Rochester, Minn.; Sidney J. Blair, Chicago, to Cook County Hospital, Chicago; Keith M. Coverdale, Fort Wayne, Ind., to a residency in pediatrics at the Naval Hospital, Philadelphia; Joseph A. Fleetwood Jr., Conway, N. C., to Medical College of Virginia Hospital, Richmond, Va.; Harry R. Freeman, Oak Park, Ill., to Cook County Hospital, Chicago; Edward M. Goldberg, Chicago, to Cook County Hospital; Charlie R. Jernigan, Tyler, Texas, to Parkland City-County Hospital, Dallas, Texas; Gene B. Kaufman, Chicago, to Cook County Hospital; Sheldon H. Kluger, Wyoming, Pa., to Philadelphia General Hospital; George P. Kochis, Whiting, Ind., to Saint Francis Hospital, Evanston, Ill.; Ralph B. Martin, Barstow, Calif., to Huntington Memorial Hospital, Pasadena, Calif.; Kenneth W. Meinert, Milwaukee, to St. Mary's Hospital, Milwaukee; Berry B. Monroe, Laurinburg, N. C., to Cincinnati General Hospital; Marshall C. Morgan, Summit, Ohio, to City Hospital of Akron; Robert F. Jejedly, Chicago, to Saint Francis Hospital, Evanston, Ill.; Lester C. Paterson, Rosedale, N. Y., to Philadelphia General Hospital; William A. Shaver, Bradford, Pa., to Graduate Hospital of the University of Pennsylvania, Philadelphia; William E. Sheely, Elizabeth City, N. C., to Philadelphia General Hospital; Jesse B. Shelmire Jr., Dallas, Texas, to the Roosevelt Hospital, New York; Vernon L. Summers, Portland, Ore., to Minneapolis General Hospital; Robert L. Swezey, Los Angeles, to Los Angeles County General Hospital; Sidney A. Tyroler, Bexley, Ohio, to Indianapolis General Hospital; David H. Walworth, Wilmette, Ill., to Evanston Hospital, Evanston, Ill.; James A. White Jr., Memphis, Tenn., to John Gaston Hospital, Memphis; Guy T. Williams, Little Rock, Ark., to St. Louis City Hospital; Robert T. Brown, Bloomdale, Ohio, to the Naval Hospital, Philadelphia; William W. Bryant, Senecaville, Ohio, to the Naval Hospital, San Diego, Calif., and Donald L. Gantt, Delaware, Ohio, to the Naval Hospital, Long Beach, Calif.

SPECIAL COURSES FOR RESERVE OFFICERS

The first of a series of five day special courses in the medical aspects of special weapons and radioactive isotopes began December 6 at the Naval Medical School, Bethesda, Md., and two hundred reserve medical officers were in attendance. The staff for these courses includes civilian consultants, representatives from the Atomic Energy Commission and Oak Ridge, Tenn., and Naval officers who specialize in the use of radioactive isotopes. Part of the courses will comprise visits to the cyclotron at the Carnegie Institute at Chevy Chase, Md., the National Cancer Institute and the National Institutes of Health.

The Surgeon General, Rear Admiral C. A. Swanson, has announced that the second course in this series will begin February 14, with only 210 vacancies open. Reserve medical officers who desire to take the course should make application to the commandant of their local Naval district prior to Jan. 17, 1949.

POSTGRADUATE INSTRUCTION

The following medical officers have been nominated for the course of postgraduate instruction indicated: Comdr. Thomas M. Foley, Washington, D. C., to a fellowship in children's orthopedics at the Shriner's Hospital for Crippled Children, Honolulu, T. H.; Lieut. James A. Kaufman, Blue Island, Ill., to a residency in surgery at the Naval Hospital, Great Lakes, Ill., and Lieut. (jg) August P. Ciell, Roxborough, Pa., to a residency in otolaryngology at the Naval Hospital, Philadelphia.

MEETING OF RESERVE MEDICAL DIVISIONS

A staff meeting of Naval Reserve Volunteer Medical Divisions 4-1 was held in Pittsburgh November 8. Those present comprised medical, dental and medical service corps officers, nurses and hospital corpsmen. Captain J. R. Thomas, Fourth Naval District medical officer, talked on the retirement plan for reserve officers which was discussed by Captain Paul Titus, M.C., U.S.N.R., and others. Naval medical motion pictures were exhibited.

RECALLED TO ACTIVE DUTY

The following medical reserve officers have been voluntarily recalled to active duty: Comdr. Lillian Hadsell, Bergen County, N. J., to the Naval Hospital, St. Albans, Long Island, N. Y.; Lieutenants (jg) Cyril J. Honsik, Oak Park, Ill., to a residency in general surgery at the Naval Hospital, National Naval Medical Center, Bethesda, Md., and Henry Santina, Chicago, to the Naval Air Station, Pensacola, Fla.

SYMPOSIUM ON DIABETES MELLITUS

The Naval Hospital, Bethesda, Md., and the District of Columbia Diabetes Association sponsored a symposium on diabetes mellitus at the Naval Medical Center, December 10, when problems in diabetes in relation to surgery, obstetrics and pediatrics were discussed. In addition to Naval officers, the speakers included Drs. Samuel Benjamin and Louis K. Alpert of Washington, D. C., and Dr. Thomas N. Carey of Baltimore.

PERSONAL

Lieut. Comdr. Margaret M. Kiehm (bacteriologist), Lieut. Frederick J. Lewis Jr. (physicist) and Lieut. Robert S. Herrmann (psychologist) have been appointed to the Medical Service Corps of the Regular Navy.

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PUBLIC HEALTH SERVICE

REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of medical officers in the regular corps of the U. S. Public Health Service will be held on Jan. 17, 1949, at various points throughout the United States. Appointments are permanent in nature and provide opportunities for a lifetime career in clinical medicine, research and public health at Marine hospitals and other Public Health Service facilities. Appointments will be made in the grades of assistant surgeon and senior assistant surgeon, for which entrance pay is, with allowance for dependents, $5,011 and $5,551. Provisions are made for promotions at regular intervals up to and including the grade of senior surgeon and for selection for promotion to the grade of medical director, at $9,751 per annum. All applicants must be United States citizens, at least 21 years of age and graduates of a recognized school of medicine. Additional information may be obtained from the Surgeon General, United States Public Health Service, Attention: Division of Commissioned Officers, Washington 25, D. C.

SURVEY OF CASES OF MULTIPLE SCLEROSIS

The Public Health Service and the National Multiple Sclerosis Society are sponsoring a survey of multiple sclerosis cases in four different parts of the country to determine incidence, prevalence and local distribution of the disease and to attempt to find out whether geographic, climatic or racial factors influence case distribution. Dr. L. T. Kurland is the Public Health Service representative on the cooperative project. The dean of a school of public health or a school of medicine will supervise each survey; the data will be gathered by public health nurses or medical students. Expenses of local teaching institutions in connection with the survey will be met by grants from the National Multiple Sclerosis Society. The physicians, hospitals and nursing homes in each area will be questioned in an attempt to record all cases in the survey areas. The first survey began in New Orleans on November 15. Subsequent surveys will be conducted in San Francisco, Boston and rural and urban areas covered by medical facilities in Minneapolis, St. Paul and Rochester, Minn.

CANCER RESEARCH

Surgeon General Scheele has approved the following nine National Cancer Institute grants totaling $82,688 to support laboratory and clinical research in cancer. The grants were recommended by the National Advisory Cancer Council at its meeting in September but were contingent on adjustment of certain items in the original request.

Research Grants

Institution	Amount Granted	Subject
Univ. of San Francisco, San Francisco	$ 3,272	Synthesis and microbiologic evaluation of amino acid analogues
Michael Reese Hospital, Chicago	12,000	Nutritional factors in the origin and growth of tumors
University of Illinois, Chicago	11,448	Study of formation of jaw tumors in a known strain of rats
Indiana University, Bloomington	7,506	Factors influencing abnormal development in mammals, with particular reference to neoplasms of thyroid and thymus tissue in man
Tulane University, New Orleans	18,576	Relationship of hormones to neoplasia
Smith College, Northampton, Mass.	4,752	Studies of tumors in plant embryos
University of Missouri, Columbia	10,000	Development of skin cancer in mice and men
University of Virginia, Charlottesville	11,880	Studies of blood in cancer patients
University of Wyoming, Laramie	3,200	The effect of deuteron bombardment on the chemical composition and carcinogenicity of organic compounds

INTERNATIONAL CONGRESS ON RHEUMATIC DISEASES

Surgeon General Scheele has announced that, on recommendation of the National Advisory Health Council, a grant of $15,000 has been approved to help finance the International Congress on Rheumatic Diseases in New York May 30-June 3, 1949. The American Rheumatism Association, which is serving as host for the Congress, will provide most of the financing. The Congress, sponsored by the International League against Rheumatism, will bring together leading authorities throughout the world on rheumatic diseases including arthritis.

DIVISIONS OF SANITATION AND WATER POLLUTION CONTROL

The Surgeon General announces a reorganization of the engineering activities of the Public Health Service, the former sanitary division being replaced by a Division of Sanitation and a Division of Water Pollution, both under the supervision of Assistant Surgeon General Mark D. Hollis. The expansion of the water pollution section into a new division is a result of the Water Pollution Act passed by Congress in 1948, which requires The Surgeon General to provide financial and technical assistance to the various states in their water pollution control programs. The chief sanitary engineering officer (Assistant Surgeon General Hollis) is responsible to The Surgeon General for the general administration of programs under the Divisions of Sanitation and Water Pollution and the Environmental Health Center, Cincinnati, which is engaged in basic research in the field of water and sewage treatment and milk and food sanitation. Sanitary Engineer Director Carl E. Schwob will be head of the new Division of Water Pollution Control, and Sanitary Engineer Director Callis H. Atkins will be head of the new Division of Sanitation.

RESEARCH ON MENTAL HEALTH

The last session of Congress authorized the Surgeon General of the Public Health Service to make grants for research in the mental health field for periods beyond the fiscal year 1948-1949. These grants, if approved during the fiscal year 1948-1949, will constitute a contractual obligation of the federal government to forward finance the research projects over and beyond the present fiscal year. Forward financing of grants to medical schools for undergraduate training in mental hygiene was also authorized. The contractual obligations for both research and training grants must not exceed $2,300,000. Initial decisions as to which institutions and individuals are to benefit from this form of forward financing will be made by the National Advisory Mental Health Council at its meeting in December. The contract authorization ceiling will not permit forward financing of all mental health grants. Consequently, some will continue to be paid under the old system, which does not obligate federal support beyond the current fiscal year.

APPOINT MENTAL HOSPITAL CONSULTANT

Dr. Riley H. Guthrie has been appointed special mental hospital consultant to the Mental Hygiene Division of the Public Health Service. He will be available after November 1 to conduct surveys of mental hospitals and provide consultive services regarding hospital administration, care of patients and other problems of mental hospitals. Requests for his services may be made by state governors, superintendents of state mental hospitals, or other qualified persons concerned with the administration of mental hospitals. Dr. Guthrie, who has been associated with state mental hospitals for twenty years, has been superintendent of the state hospital at Norwich, Conn., for two years. Previously, he served on the staffs of St. Elizabeth's Hospital, Washington, D. C.; Boston Psychopathic Hospital; Massachusetts Department of Mental Diseases; Monson State Hospital, Palmer, Mass.; Massilon State Hospital, Massilon, Ohio, and Arkansas State Hospital, Little Rock.

Medical News

(Physicians will confer a favor by sending for this department items of news of general interest: such as relate to society activities, new hospitals, education and public health. Programs should be received at least two weeks before the date of meeting.)

COLORADO

Dr. Ruck to Head Department of Biophysics.—The University of Colorado announces the establishment of a department of biophysics at the University Medical Center in Denver. A graduate program leading to a Ph.D. degree in biophysics will be offered. Courses of instruction include training in the use of radioactive isotopes in biology, the interactions of ionizing radiations with living systems, study of the behavior of biologically important macromolecules and biostatistics. The department will also take part in the Atomic Energy Commission's program for postdoctoral training in biophysics. A research program centering about cellular growth processes and study of the radiation chemistry of artificially induced mutations is now being set up. Theodore Puck, Ph.D., formerly of the departments of medicine and biochemistry of the University of Chicago, has been named head of the department.

CONNECTICUT

Personal.—Dr. Hilda H. Kroeger, director of Maternal and Child Health in the state department of health, Phoenix, Ariz., has been appointed assistant director of Grace-New Haven Community Hospital and professor of hospital administration at Yale University. Dr. Kroeger received her M.D. degree from Rush Medical College in 1932.

State Association Medical Service Plan.—The Connecticut State Medical Society at the semiannual meeting of the society's house of delegates December 9 adopted a prepayment plan through which state residents may meet costs of maternity and surgery. It offers full payment of doctor's fees for childbirth or surgery to subscribers whose annual incomes do not exceed the following amounts: $3,500 for subscriber and family; $3,000 for subscriber and one dependent, and $2,500 for individual subscriber. Subject to further study by actuaries, tentative monthly subscription rates are 75 cents for subscriber only; $1.50 for subscriber and one dependent, and $2.25 for subscriber and family. The plan will be operated on nonprofit principles, in cooperation with the Connecticut Blue Cross organization. Control will be exercised through the Connecticut Medical Service, a new corporation whose board of directors will comprise six licensed physicians appointed by the state medical society and six members named by the Connecticut Blue Cross. A Professional Policy Committee of nine physicians will determine and recommend action in all matters involving medical ethics and professional practice. Enrolment of physicians in the plan will be purely voluntary. Those enrolling will agree to accept the amounts listed in the plan's schedule of fees as full payment for subscribers whose incomes do not exceed the stated levels. For subscribers whose incomes are above the stated limits any additional charge will be subject to patient-physician agreement. Membership in the plan will be open without physical examination or age limit to all persons holding Blue Cross Hospital Service contracts.

ILLINOIS

Increase in Diabetes in Illinois.—According to the Illinois State Department of Public Health the incidence of diabetes has shown a steady upward trend in the state during the past twenty-five years. With 1,367 deaths reported in 1922, mortality from diabetes was at a rate of 19.6 per 100,000 population. By 1932 the toll had climbed to 2,079, or a death rate of 25.8, and in 1947 the number of deaths due to diabetes totaled 2,735, with a rate of 33.3 per 100,000 population.

Chicago

Hospital News.—Work began November 30 on a four story 75 bed addition to the South Shore Hospital costing $850,000. The new structure, for general medical, surgical and obstetric cases, will have four new operating rooms, two delivery rooms, four labor rooms, six nurseries and additional laboratory and utility space. A blood bank will also be set up as a new service by the hospital.

Course in Electrocardiographic Interpretation.—A course in electrocardiographic interpretation for graduate physicians will be given at the Michael Reese Hospital Postgraduate School each Wednesday from 7 p.m. to 9 p.m. for twelve weeks beginning Feb. 9, 1949. Information may be obtained from Dr. Samuel Soskin, Dean, Michael Reese Hospital Postgraduate School, 29th Street and Ellis Avenue, Chicago 16.

Personals.—Dr. Stanley Gibson will retire January 1 as chief of staff of Children's Memorial Hospital, having attained the retirement age. He will continue on the medical staff of the hospital as consulting cardiologist. Dr. Gibson has been on the staff since 1932 and chief of staff since 1944. Dr. John A. Bigler, a member of the medical staff since 1931 and medical director since 1944, has been appointed chief of staff.

Organize Diabetes Association.—A group of Chicago physicians, nurses, dietitians and laymen have organized the Chicago Diabetes Association, which eventually will be incorporated and will apply for affiliate status to the American Diabetes Association, on whose invitation the Chicago association was formed. Officers are Dr. Arthur R. Colwell, president; Dr. Samuel Soskin, vice president; Dr. Henry T. Ricketts, secretary, and Mr. Paul Dice, treasurer. After the organizing procedures are completed, membership will be expanded to include other physicians, nurses and dietitians, as well as social workers and technicians.

IOWA

Society News.—Private practitioners and representatives of each of the state's mental institutions have organized the Iowa Neuro-Psychiatric Society with Dr. Paul E. Huston, Iowa City, as president and Dr. Grace M. Sawyer of Woodward, secretary.——The Linn County Medical Society on January 13 will hear Dr. Robert L. Sanders, Memphis, Tenn. speak on "The Peptic Ulcer Problem with Special Reference to Bilateral Vagal Resection."

KENTUCKY

State Medical Election.—The Kentucky Medical Association installed Dr. Charles A. Vance, Lexington, as president and chose Dr. Hugh L. Houston, Murray, as president elect at its annual meeting in September. Dr. Bruce Underwood, Louisville, was elected secretary. Dr. Houston, at the age of 40, is reported to be the youngest president in the history of the organization. He received his M.D. degree from Vanderbilt University School of Medicine, Nashville, 1933.

Portrait of Irvin Abell.—A portrait of Dr. Irvin Abell Sr., an alumnus and member of the Board of Trustees of the University of Louisville, was recently presented to the School of Medicine. Dr. Fred W. Rankin, Lexington, in the presentation speech cited Dr. Abell as "the most distinguished alumnus of this university, [who] has shed lustre on his Alma Mater by his professional accomplishments, his Christian example, and his devoted service to the organized medical profession." Dr. Abell is a former president of the American Medical Association.

LOUISIANA

Personal.—Dr. E. W. Alton Ochsner, William Henderson professor of surgery at Tulane University of Louisiana School of Medicine, New Orleans, has been reappointed consultant to the headquarters, U. S. Air Force.

Cancer Research.—Tulane University of Louisiana School of Medicine, New Orleans, has received a grant of $47,452 from the American Cancer Society to expand the specialized care and study of selected patients regardless of their ability to pay.

Founder's Day Forum.—The Rapides Parish Medical Society and the Eighth District Medical Society are sponsoring the Annual Founder's Day Forum Jan. 15, 1949 at the Hotel Bentley in Alexandria. This meeting will be attended by members of the medical profession from Central Louisiana and will be conducted by members of the teaching staff of Tulane University and Louisiana State University of New Orleans. Subjects to be discussed include "The Use of Blood and Blood Substitutes," "Early and Late Treatment of Traumatic Injuries with Special Reference to those of the Face," "Carcinoma of the Colon" and "Mycotic Infections of the Skin."

MARYLAND

Society News.—The Montgomery County Medical Society, which meets on the third Tuesday of each month at 8:15 p. m. at the Manor Country Club, Norbeck, has arranged the following meetings for 1949:

Jan. 18, T. Wiley Hodges, Richmond, Va., The Bone Graft in Reconstructive Surgery.
Feb. 15, Norman H. Topping, Bethesda, Md., Research Program of the National Institutes of Health.
March 15, Robert J. Reeves, Durham, N. C., Diagnostic Problems in Radiology.
April 19, Wallace E. Herrell, Rochester, Minn., Anti-Biotics and Clinical Medicine.

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MICHIGAN

State Medical Election.—The Michigan State Medical Society at its meeting in September elected the following officers for 1948 and 1949: Dr. Edward F. Sladek, Traverse City, president; Dr. William E. Barstow, St. Louis, president elect, and Dr. L. Fernald Foster, Bay City, secretary.

Report of Mediation Committee.—Eighteen months ago the Wayne County Medical Society appointed a mediation committee to analyze and adjust all complaints having to do with the economics of the practice of medicine against members of the society in Detroit and environs. Only thirty-seven complaints from a population of 2,500,000 have been received in one and one-half years.

Postgraduate Clinical Conference.—The third annual Michigan Postgraduate Clinical Institute, sponsored by the Michigan State Medical Society, Wayne County Medical Society, University of Michigan Medical School and Department of Postgraduate Medicine, Wayne University College of Medicine, Ann Arbor, and the Michigan Foundation for Medical and Health Education, Inc., will be held at the Book-Cadillac Hotel, Detroit, March 23-25, 1949. The complete program will be announced in January. A "Heart and Rheumatic Fever Day" on March 26 will follow the institute. Members of American and Canadian medical associations are invited to the institute, as well as to the heart conference. There is no registration fee.

NEVADA

State Medical Election.—The Nevada State Medical Association chose Dr. Rodney E. Wyman, Reno, president; Dr. David E. Hemington, Las Vegas, president-elect, and Dr. Roland W. Stahr, Reno, secretary-treasurer, for the coming year.

NEW JERSEY

Organize Speakers' Bureau.—The Camden County Medical Society has organized a Speakers' Bureau with an initial complement of twenty-six speakers. Letters have been sent to more than 1,000 organized lay groups in the county indicating that requests for medical speakers will receive consideration.

Martland Lecture.—The thirteenth annual Harrison S. Martland Lecture under the auspices of the Essex County Pathological and Anatomical Society was given in Newark December 7 by Dr. Shields Warren, Boston, on the "Pathology of Diseases of the Thyroid with the Present Status of Radioactive Treatment."

Blood Banks.—A growing number of communities in New Jersey are reported to have organized "walking blood banks." Prospective blood donors are recruited by the American Red Cross and typed for donation of blood if, as and when needed. Union Township is the latest to set up such a blood bank with the cooperation of the Union Township Medical Society and the Elizabethtown Red Cross Chapter. A similar program is contemplated for Mercer County and has the endorsement of the county medical society.

Medical School Proposal Approved.—Governor Alfred E. Driscoll has approved a proposal of the Medical Society of New Jersey for a committee to study the "need for the development and operation of an approved medical school" for New Jersey. The society's proposal is that a representative committee be appointed to be composed of sixteen members, four of whom would be designated by the medical society, four by Rutgers University in New Brunswick, and eight public members appointed by the governor. On completion of its study the committee will be requested to make its recommendations to the governor and the legislature. This is viewed as the first formal step toward the eventual accomplishment of the objective long sought by the Medical Society of New Jersey.

NEW YORK

Regional Health Offices.—New York's six regional health offices are now in operation. Dr. Robert L. Vought is director of the lately opened New York City Suburban Regional Office in White Plains. Dr. Ralph M. Vincent assumed duties as head of the Albany regional office on October 28. The first three regional offices were opened in Buffalo, Rochester and Syracuse early in August, with Drs. Archibald S. Dean, Buffalo, Joseph P. Garen, Rochester, N. Y., and Ray D. Champlin, Oneonta, N. Y., as regional directors. The sixth regional office was opened in November and will operate under the direction of Dr. Philip J. Raffe, former district state health officer for the state health district in New York City. The regional offices were established early this year (THE JOURNAL, February 28, p. 635).

New York City

Residencies Available.—Residencies in neurology are now available under the Veterans Administration program, beginning Jan. 1, 1949 at the Bellevue Psychiatric Hospital, New York. Applications may be secured by writing Professor S. Bernard Wortis, New York University College of Medicine, Department of Neurology, 400 East Thirtieth Street, New York 16.

Dr. Bernecker to Retire.—Dr. Edward M. Bernecker, commissioner of hospitals since March 1942, will retire December 31. Dr. Bernecker entered city service in 1915 as an intern in Metropolitan Hospital on Welfare Island, where he became resident physician and in 1927 deputy medical superintendent. He was medical superintendent and later general superintendent in Kings County Hospital in Brooklyn.

The James Ewing Cancer Hospital.—Cornerstone ceremonies for the ten story 300 bed James Ewing Hospital for cancer, to be affiliated with the Memorial Cancer Center, were held November 26. Construction costs of the hospital, expected to be completed late next year, will total $5,632,250. The hospital was named by the city, which will operate it for the care and treatment of long term cancer patients and research, in honor of the late Dr. James Ewing because of his long association with Memorial Hospital. Construction of the hospital began on Jan. 24, 1947 (THE JOURNAL, Feb. 8, 1947).

Appoint Head of Public Health Education Division.—Dr. Llewellyn E. Kling, formerly of the U. S. Public Health Service, has been appointed associate professor of public health education and head of the Public Health Education Division in Columbia University School of Public Health. He is a graduate of Louisiana State University School of Medicine, New Orleans, and studied public health at Columbia. He has been county health officer in Nebraska and served for six years as a commissioned officer in the public health service active in tuberculosis and cancer educational and control work. He has served more recently as medical director of the Planned Parenthood Federation.

Personals.—Dr. Arthur Sayer was recently appointed associate clinical professor of dermatology at the New York Medical College, Flower and Fifth Avenue Hospitals. Dr. Sayer, a graduate of the Columbia University College of Physicians and Surgeons, has been an attending dermatologist at the Morrisania City Hospital.——Dr. George G. Deaver, professor of clinical rehabilitation and physical medicine at New York University College of Medicine, has been awarded the Medal of Merit for pioneer work in the field of rehabilitation.——Dr. Carl R. Wise, instructor in medicine at the Columbia University College of Physicians and Surgeons, has succeeded Dr. William H. McCastline as university medical officer. Dr. McCastline retired last June. Dr. Wise, a graduate of Harvard Medical School, Boston, served in the medical corps in World War II.——Dr. Edward H. Mandel was recently made correspondent member of the Japanese Dermatological Association in the United States.

Immunize Dogs Against Rabies.—The health department's experimental campaign in Staten Island for the elimination of rabies is reported as being received apathetically by dog owners in the second year of its operation. Vaccination of all licensed dogs was made compulsory after an outbreak of rabies in Staten Island last year. Vaccination centers were set up in various parts of boroughs in June 1947, after which 11,000 of the island's 14,000 licensed dogs were immunized. During the second year of the experiment, however, only 3,800 dogs have been inoculated thus far, and only a few of the animals vaccinated last year have been brought back for a second injection. The health department is sending letters to all dog owners warning them to have their pets inoculated again; new dog owners are being informed concerning the ruling. Seven rabid dogs have been found on Staten Island, compared with 18 last year. The last death reported in the city from the disease was in 1944.

NORTH CAROLINA

State Cancer Centers.—Since March 1, 1948, when the Division of Cancer Control of the North Carolina State Board of Health was activated, cancer centers have been set up at Wilmington, Asheville and Winston-Salem. Specialists make a diagnosis, which with the recommendations is sent by letter to the patient's personal physician. Only men and women 40 years of age or older are admitted to these clinics. A survey of work done by the clinics operating an average of three and a half months reveals that of 1,277 persons examined, 76 were found to have cancer; that represents more than 6 per cent of the total number examined, and twelve times the average found in detection clinics throughout the nation, according to Dr. John W. R. Norton, acting state health officer. The State Board of Health by authority of the Cancer Act in 1945 set up the North

Carolina Cancer Control Program. Affiliated agencies are the Medical Society of the State of North Carolina and the American Cancer Society, North Carolina Division. Funds are derived from appropriations by the U. S. Public Health Service and the State Legislature, and the Cancer Division donated $25,000 in 1946 to administering the program.

OKLAHOMA

Personal.—Dr. John F. Hackler, professor of preventive medicine and public health since 1943 at the University of Oklahoma School of Medicine, Oklahoma City, resigned October 1, to accept a position as director of the City-County Health Department, Muskogee.

Narcotic Violation.—According to the Bureau of Narcotics, Dr. Edward C. Keyes, Pawhuska, pleaded guilty to violation of the Federal Narcotic Law in the U. S. District Court at Tulsa September 29. A sentence of two years was suspended and he was placed on probation for a like period.

Fifty Years in Practice.—More than one hundred Tulsa County physicians met last month to pay tribute to Dr. W. Albert Cook, who has served in the medical profession for more than fifty years, and Dr. Pleasant P. Nesbitt. Dr. Nesbitt received the plaque in recognition of his service as past president of the Oklahoma Medical Association in 1925. Dr. Patrick H. Mayginnes, who was unable to attend, was awarded a gold medal for fifty-one years of active practice in Tulsa. Dr. Cook was the first president of the Tulsa County Medical Society, in 1907.

PENNSYLVANIA

Society News.—At a recent meeting of the Reading Eye, Ear, Nose and Throat Society, Dr. Philip R. Wiest, Reading, discussed "The Sphenopalatine Ganglion."

State Society Desires Names of Centenarians.—The Medical Society of the State of Pennsylvania, which has just celebrated its centennial, desires to share birthday honors with all residents of the state who will be 100 years old during 1949. A framed testimonial will be presented to each centenarian on his or her birthday. Those who will be 100 years old next year may write to The Medical Society of the State of Pennsylvania, 230 State Street, Harrisburg.

Philadelphia

Cancer Detection Clinic and Tumor Registry.—A cancer detection clinic was opened in Frankford Hospital November 9, the first of a network to be set in operation by the Philadelphia Division of the American Cancer Society. The purpose is to examine persons for presymptomatic cancer. Appointments may be made for examinations on Tuesday afternoons. A Tumor Diagnostic Service and Registry for Children has been established at St. Christopher's Hospital for Children in conjunction with the pediatric department of Temple University Hospital. The service is available to any hospital in the state and is made possible by assistance from the New York State Department of Health through its Cancer Fund. Gross specimens should be sent through the pathology department of the hospital. No fee will be charged by St. Christopher's Hospital, and whatever charge is made to a patient will be by the pathologist or hospital sending the specimen.

SOUTH CAROLINA

Speakers' Bureau.—The South Carolina Medical Association's Committee on Maternal Welfare is organizing a speakers' bureau, the members of which will be available not only to the committee but also to interested groups of women and to medical societies as speakers on subjects pertaining to child bearing. Inquiries should be addressed to Dr. Manley E. Hutchinson, chairman, 1412 Bull Street, Columbia. The bureau was set up to aid the association's committee which had been in operation a number of years but was discontinued during the war. Its purpose is to conduct studies in the circumstances of all deaths of South Carolina mothers and to determine what changes in treatment should be made. The South Carolina Obstetrical and Gynecological Society will cooperate in the educational program. Committee chairman is Dr. J. Decherd Guess, Greenville.

WISCONSIN

Appoint Assistant Dean.—Dr. Otto A. Mortensen, professor of anatomy at the University of Wisconsin, has been appointed assistant dean of the University of Wisconsin Medical School, Madison. He is a graduate of the University of Wisconsin Medical School, Madison, 1929, and has been on the staff of the medical school since 1930.

Course in Gastroenterology.—The University of Wisconsin Medical School, Madison, through its division of graduate medical education is presenting a five day course in gastroenterology February 14-18 at the Wisconsin Medical School, under the supervision of Dr. Karver L. Puestow and Dr. Frank L. Weston. The course will include proctoscopic and gastroscopic demonstrations, discussion of technics, parasitic diseases of the intestinal tract, food poisoning, toxemias, malignant disease, roentgen ray and surgical aspects of therapy, jaundice and its causes, along with other disorders of function and physiology. Enrolment will be limited to twelve physicians. Applications may be made to Dr. Llewellyn R. Cole, the Medical School, 418 North Randall, Madison 6.

GENERAL

Executive Director of Heart Association.—Mr. Rome A. Betts, general secretary of the American Bible Study since 1942, will become the first executive director of the American Heart Association January 1. He will be responsible to the Board of Directors for the functions of the three main administrative divisions: medical, public health and fund raising. The association and its affiliates in the major areas of the United States will conduct a nationwide campaign February 7-28, 1949, to raise $5,000,000 to combat diseases of the heart and circulation.

Multiple Sclerosis Fund.—At a luncheon of the Association for Research in Nervous and Mental Disease December 10, the National Multiple Sclerosis Society announced plans to raise a Research and Educational Fund of $225,000 for 1949. The National Multiple Sclerosis Society was founded in October 1946. Richard I. Straus, New York, is president and Dr. Tracy J. Putnam, Beverly Hills, Calif., is chairman of its medical advisory board. Offices are in the New York Academy of Medicine Building, Fifth Avenue and 103rd Street, New York 29.

Section Meetings.—The section meetings of the American Laryngological, Rhinological and Otological Society, Inc., will be held in January. The Eastern Section will meet at the Hotel Puritan, Boston, January 7. Those invited to deliver papers are Drs. Laurence L. Robbins, W. Lloyd Aycock, Conrad Wesselhoeft and John F. Enders, Ph.D., all of Boston. The Southern Section meeting will be held at the Hotel Raleigh, Washington, D. C., January 10. Invited speakers are Drs. Russell C. Grove, New York, and Edwin N. Broyles, Baltimore. University Hospital, Iowa City, is the headquarters for the Middle Section meeting January 17. Those speaking by invitation are Drs. John B. Erich, Rochester, Minn., Jerome A. Hilger, St. Paul, Minn., and Adolph L. Sahs, Iowa City. The Western Section meeting will be held in the Los Angeles County Medical Building, Los Angeles, January 29-30.

Scholarship Fund.—The Delta Gamma Fraternity has a $1,500 annual fund and a $2,000 annual loan fund from which smaller scholarship awards are available for preparation of those intending to become (1) orthoptic technicians, (2) teachers of partially seeing children or (3) specialists for blind preschool children. Any person wishing to specialize in one of these fields is eligible for assistance, the amount in each case to be determined by the particular need and costs involved. Applications may be made to Mrs. Thomas Johnson, 1235 Longfellow, Detroit 2. Applications for scholarships should be filed by March 15 for training starting in June; for training starting in the fall by July 15. Candidates are selected with the advice of a professional committee under the chairmanship of Dr. LeGrand H. Hardy, New York, of the American Orthoptic Council.

Society Elections.—The American Society of Anesthesiologists has installed Dr. H. Boyd Stewart, Tulsa, Okla., as president, and elected Dr. Rolland J. Whitacre, East Cleveland, Ohio, as president elect; Dr. Curtiss B. Hickcox, Philadelphia, and Dr. Moses H. Krakow, New York, continue as secretary and treasurer respectively.——At the recent meeting of the National Society for Crippled Children and Adults, Dr. John J. Lee, dean of the Graduate School, Wayne University, Detroit, was elected president, succeeding Colonel Elbridge W. Palmer, Kingsport, Tenn.——The American Cancer Society has elected Dr. Clifford C. Nesselrode, professor of surgery, University of Kansas School of Medicine, Kansas City, as national president; Charles D. Hilles, New York, secretary, and J. Ernest Allen, treasurer. Dr. Nesselrode has served on the society's board since the beginning of the organization.——The Mississippi Valley Conference on Tuberculosis recently chose as its president Dr. Oscar Lotz, executive secretary of the Wisconsin Anti-Tuberculosis Association.——The Mississippi Valley Trudeau Society selected Dr. Christopher J. Stringer, Lansing, Mich., president, Dr. John D. Steele, Milwaukee, Wis., president elect and Dr. Gustaf A. Hedberg, Nopeming, Minn., secretary-treasurer.

Cancer Monographs.—The American Cancer Society is planning to distribute a series of monographs written by distinguished physicians and designed to emphasize some of the more important measures that can be used by the doctor in detecting early cancer. To provide visual concepts of early diagnostic signs these 20 to 30 page brochures will be illustrated in color, and they will be uniform in format and size so that they may be conveniently incorporated into a binder. It is desired to place them in the hands of as many practicing physicians throughout the country as possible. The first, The Cancer Problem, by Dr. Shields Warren, Boston, will be ready for distribution by Jan. 1, 1949; the others will be released periodically. Titles and their authors are as follows: Head and Neck, by Hayes E. Martin, New York; Skin, by Dr. S. William Becker; Esophagus and Stomach, by Owen H. Wangensteen; Large Intestine and Rectum, by Thomas E. Jones; Larynx-Pharynx, by Chevalier L. Jackson Jr.; Thyroid, by John Pemberton; Lung, by Richard J. Overholt; Breast, by Cushman D. Haagensen; Female Pelvic Organs, by Herbert F. Traut; Genitourinary, by Victor Marshall; Soft Part Tumors, by John J. Morton, and Lymphomatous Diseases, by Lloyd F. Craver.

Board for Certification of Orthopedic Appliances.—To improve the professional standards of manufacturers of artificial limbs and braces and the fitters employed by such firms, an American Board for Certification of the Prosthetic and Orthopedic Appliance Industry, Inc., has been established in Washington, D. C. with headquarters at 336 Washington Building. Three orthopedic surgeons and four leaders in the orthopedic appliance industry constitute the national board which will grant certification. The orthopedic surgeons are Dr. Rufus H. Alldredge, New Orleans; Dr. Henry H. Kessler, Newark, N. J., and Dr. Atha Thomas, Denver. Lay members of the board are Chester C. Haddan, Denver; Lee J. Fawver, Kansas City, Mo.; J. B. Korrady, Chicago, and David E. Stolpe, New York. Mr. Haddan is president, and Glenn E. Jackson is executive director. To be qualified for certification an applicant must prove that he has had at least four years of actual experience under proper supervision or two years of special training and one year of experience. In addition, the applicant must present the signature of two physicians who state that he meets various other requirements. More than one hundred firms and two hundred fitters have already applied for certification. The medical profession has been of invaluable assistance during the two years of intensive work which resulted in the incorporation of the board.

Fellowships in Exfoliative Cytology.—The American Cancer Society has made available twenty-three fellowships in exfoliative cytology at nine of its laboratories in order to provide training in diagnostic technics for qualified pathologists. These four month fellowships will be awarded by institutions or laboratories designated by the society on the basis of past training and the intention to teach diagnostic technics to interested pathologists, clinicians and technicians. Applicants must be graduates of class A medical schools, citizens not over 50 years of age and must have completed two years of postgraduate training in pathology. Stipends will be paid in two sums: the first to the laboratory; the second to the trainee partially to cover his expenses in the amount of $140 per month in advance. Applications should be made to one of the following laboratories. The number in parentheses indicates the number of fellowships available at that laboratory: Cornell University Medical College, New York (6), George N. Papanicolaou; Jefferson Hospital, Philadelphia (6), Lewis C. Scheffey; University of Oregon Medical School, Portland (2), Warren C. Hunter; University of California Hospital, San Francisco (2), Herbert F. Traut; Michael Reese Hospital, Chicago (2), Otto Saphir; Hartford Hospital, Hartford, Conn. (2), Ralph E. Kendall; New York Post-Graduate Hospital, New York (1), Locke L. Mackenzie; Free Hospital for Women, Brookline, Mass. (1), Arthur T. Hertig; Mayo Clinic, Rochester, Minn. (1), John R. McDonald.

United Mine Workers' Welfare and Retirement Fund.—The United Mine Workers of America Welfare and Retirement Fund is concerned in the main with pensions, disability benefits, death benefits and medical, health and hospital services for members of the organization. In the last mentioned, it is the purpose of the fund to provide a prepaid form of hospital service and medical attention in all of the districts and in all local unions. Arrangements are being made to utilize present medical and hospital services under conditions which guarantee high standards of medical and hospital care and are satisfactory to the physicians, the hospitals and the fund alike. When these arrangements are completed in a given district, it will mean that the expense of medical and hospital services will be borne by the United Mine Workers' Welfare and Retirement Fund and that the members will be freed from paying a monthly amount deducted from their wages—so much a month to the hospital fund and so much a month to the doctor, as now exists in many places. It is possible that experience may demonstrate the necessity of providing additional and more specialized facilities for meeting the needs, but this will come from knowledge gained through present procedure and through the availability of funds.

The administration of the medical and hospital work is under the general direction of Dr. Warren F. Draper, former Deputy Surgeon General of the United States Public Health Service and Major General in charge of the Public Health Branch at Supreme Headquarters Allied Expeditionary Forces during World War II. He served also as State Health Commissioner of Virginia and as a member of the House of Delegates of the American Medical Association from 1925 to 1946. Medical administrative offices, each in charge of a full time physician employed by the fund and working under the direction of the Executive Medical Officer, are being established at ten locations in or near the soft coal mining areas as follows:

Denver, serving Districts 10, 15, 22, 27, Dr. William Dorsey.
Johnstown, Pa., serving District 2, Dr. Leslie A. Falk.
Pittsburgh, serving Districts 3, 5, 6, Dr. Richard F. Boyd.
Morgantown, W. Va., serving Districts 31, 16, 4, Dr. Lorin E. Kerr.
Charleston, W. Va., serving District 17, Dr. John T. Morrison.
Beckley, W. Va., serving District 29, Dr. Deane F. Brooke.
Knoxville, Tenn., serving Districts 19, 28, Dr. John D. Winebrenner.
Birmingham, Ala., serving District 20, Dr. J. Herbert Scheffer.
St. Louis, serving Districts, 12, 13, 14, 21, Dr. Cecil A. Z. Sharp.
Louisville, Ky., serving Districts 8, 11, 23, 30, Dr. Asa Barnes.

The area medical administrators, in collaboration with the physicians and hospitals in the Districts, will work out simple and satisfactory agreements for providing medical and hospital care to eligible members and their dependents. The detailed arrangements may vary to some extent according to conditions within the Districts. In the beginning the activities will be directed to the hospitalization of those who are receiving disability benefits and pensions and therefore cannot obtain services through a check-off on their wages. Included also will be United Mine Workers of America members with serious conditions for which adequate treatment facilities are not available in the localities where they live. Through this approach the area medical administrators will be able to establish procedures and train their personnel before assuming a larger work load. The program will be extended gradually as the necessary arrangements can be made.

Medical societies and leading members of the medical profession have given assurance of their desire to demonstrate the practicability of the program and make it a success. With an enterprise of such far reaching significance, it is the hope of the fund that the physicians and hospitals of this country, with the aid of their organizations, will join in an undertaking to render high standards of medical and hospital care at as reasonable cost as such quality of care could be furnished under any system that could be devised.

Marriages

HERBERT LEE WORMHOUDT, Cincinnati, to Miss Hazel Rebecca Durden of Fernandina, Fla., in Washington, D. C., September 4.

FRANK WARREN HOWARD, Benton Harbor, Mich., to Miss Sarah Jane Yonkman of Grand Rapids, October 2.

EDWARD CRAIG HAMILTON, Mobile, Ala., to Miss Elizabeth Courtenay of Greenville, S. C., October 16.

JOSEPH JUSTIN MCCARTHY JR., to Miss Mary Lourdes Riley, both of Washington, D. C., October 16.

WILLIAM J. CATHEY, Portland, Ore., to Miss Patricia Gene Person of Veradale, Wash., October 2.

MALCOLM E. RUBEN, Washington, Pa., to Miss Ruth Elva Wilson in Chicago, September 4.

LAWRENCE J. ESSEMBER JR., Peabody, Mass., to Miss Gertrude T. Bugler of Salem, October 2.

CHARLES ALLEN ASHLEY to Miss Audrey Waite, both of Bronxville, N. Y., October 9.

LESTER A. STEINBERG, Bridgeton, N. J., to Miss Esther Saxe of Newton, Mass., recently.

HARRY ALDEN WALL to Mrs. Bessie Nye Mattox, both of Norfolk, Va., October 9.

ROBERT A. HOFFMAN to Miss Phyllis Strause, both of Richmond, Va., October 16.

Deaths

Charles R. Robins, Richmond, Va.; born in Richmond, Dec. 31, 1868; Medical College of Virginia, Richmond, 1894; professor of gynecology at his alma mater from 1907 to 1938, when he became emeritus professor; member of the founders group of the American Board of Surgery; member of the Southern Surgical Association, of which he had been vice president, Tri-State Medical Association of the Carolinas and Virginia, American Medical Association and the South Atlantic Association of Obstetricians and Gynecologists; past president of the Richmond Academy of Medicine; fellow of the American College of Surgeons; served during World War I; member of the school board; formerly director of the State Planters Bank and Trust Company; a founder and for many years president of the board of directors of the Stuart Circle Hospital; affiliated with the Retreat for the Sick and the Sheltering Arms Hospital; past president of the Rotary Club; died October 16, aged 79, of coronary sclerosis.

Horace Gilbert Smithy Jr., Charleston, S. C.; born in Norfolk, Va., July 19, 1914; University of Virginia Department of Medicine, Charlottesville, 1938; assistant professor of surgery at the Medical College of the State of South Carolina; specialist certified by the American Board of Surgery; served an internship and residency at the Roper Hospital, where he was a fellow in surgery; member of the American Medical Association; fellow of the American College of Surgeons; is said to have performed the first successful heart valve operation; surgeon at Roper Hospital, where he died October 28, aged 34, of aortic stenosis.

Bernard Philip Conway, Chicago; Chicago College of Medicine and Surgery, 1914; member of the American Medical Association; received the Croix de Guerre and the Purple Heart for bravery in action during World War I; formerly chief surgeon for the Hartford Accident and Indemnity Company of Hartford, Conn., whose examiner he has been for over thirty years; since 1942 supreme medical examiner and a member of the managing committee of the Royal League; died in the Presbyterian Hospital November 4, aged 61, of bronchopneumonia following an operation.

Francis Marion Bair, Cuba City, Wis.; Baltimore University School of Medicine, 1899; member of the American Medical Association; died September 25, aged 74, of endocarditis.

Samuel Edward Ballard, Long Beach, Calif.; Baltimore Medical College, 1899; member of the American Medical Association; on the staff of the Community Hospital; died September 20, aged 74, of coronary occlusion.

Louis C. Bauman ● St. Joseph, Mo.; Central Medical College, St. Joseph, 1904; an Associate Fellow of the American Medical Association; past president of the Buchanan County Medical Society; died in Rochester, Minn., September 15, aged 73, of hypertrophy of the prostate and parkinsonism.

George Lewis Cable, Denver; Starling Medical College, Columbus, 1897; died recently, aged 75.

George William Carson, St. Louis; Barnes Medical College, St. Louis, 1901; died October 22, aged 70, of pneumonia.

Edwin James Cauffield, Akron, Ohio; Cleveland University of Medicine and Surgery, 1895; for many years on the staff of City Hospital, where he died October 8, aged 76, of toxemia.

Edgar Boykin Clark ● Philadelphia; Meharry Medical College, Nashville, Tenn., 1928; died recently, aged 46.

Leonard Easton Claydon ● Red Wing, Minn.; University of Minnesota College of Medicine and Surgery, Minneapolis, 1895; died August 15, aged 79, of chronic bronchiectasis.

Samuel Walter Cottle ● Morgantown, W. Va.; University of Louisville (Ky.) School of Medicine, 1925; died October 31, aged 49, of a head injury sustained in a fall.

Joseph Francis Cusick, Binghamton, N. Y.; Georgetown University School of Medicine, Washington, D. C., 1931; member of the American Medical Association; an officer during World War II; served on the staffs of Our Lady of Lourdes Memorial Hospital and Binghamton City Hospital, where he died October 13, aged 41, of peptic ulcer with massive gastric hemorrhage.

Frank E. Dawson, Detroit; Meharry Medical College, Nashville, Tenn., 1917; member of the American Medical Association; died October 12, aged 70, of carcinoma of the stomach.

Persis F. Elfeld ● Wilmington, Del.; University of Illinois College of Medicine, Chicago, 1923; member of the American Psychiatric Association; for many years associated with the Delaware State Hospital in Farnhurst; died recently, aged 50, of heart disease.

Ray Eugene Persons ● Cairo, N. Y.; Albany (N. Y.) Medical College, 1916; past president of the Greene County Medical Society; president of board of education; director of the First National Bank; chief of staff, Memorial Hospital of Greene County, Catskill; died September 29, aged 57, of carcinoma.

James Hardy Pittman, West Palm Beach, Fla.; Vanderbilt University School of Medicine, Nashville, Tenn., 1899; member of the American Medical Association; formerly associated with the U. S. Public Health Service; affiliated with Good Samaritan and St. Mary's hospitals; died September 23, aged 75, of uremia.

Wayne S. Regar, Ephrata, Pa.; Medico-Chirurgical College of Philadelphia, 1907; member of the American Medical Association; died October 3, aged 76, of injuries received in an automobile accident.

William Reid, Deerwood, Minn.; Trinity Medical College, Toronto, Canada, 1892; died in Grand Rapids, September 9, aged 82, of carcinoma of the colon.

Ella N. Ritter, Williamsport, Pa.; Woman's Medical College of Pennsylvania, Philadelphia, 1893; member of the American Medical Association; died in Darlington Sanitarium, West Chester, September 30, aged 82.

Howard Royer, Grand Island, Neb.; University of Nebraska College of Medicine, Omaha, 1930; member of the American Medical Association; served overseas in the medical corps of the U. S. Naval Reserve during World War II; affiliated with St. Francis and Lutheran hospitals, died October 15, aged 43, of chronic nephritis and uremia.

Charles Bradley Russell ● Paterson, N. J.; Harvard Medical School, Boston, 1904; served during World War I; affiliated with the New Jersey Orthopedic Hospital, Orange, Nathan and Miriam Barnet Memorial Hospital and St. Joseph Hospital, where he died October 26, aged 72, of coronary thrombosis and carcinoma of the bladder.

Morris Samsky, Brooklyn; Long Island College Hospital, Brooklyn, 1912; died in October, aged 59.

John Theodore Schlesselman, Mankato, Minn.; Cleveland University of Medicine and Surgery, 1897; member of the American Medical Association; fellow of the American College of Surgeons; affiliated with St. Joseph's and Immanuel hospitals; died September 6, aged 71, of coronary thrombosis.

Cyril Evan Sheppard ● Larned, Kan.; University of Kansas School of Medicine, Kansas City, 1914; during World War I served in the medical corps of the U. S. Army; for two terms mayor of Larned; affiliated with St. Rose Hospital in Great Bend; died September 14, aged 63, of myocardial infarction.

Korah Ellis Sherrill, Fulton, Mo.; Barnes Medical College, St. Louis, 1911; member of the American Medical Association; died September 4, aged 75.

William Smith Shimer, Philadelphia; University of Pennsylvania Department of Medicine, Philadelphia, 1886; served during World War I; affiliated with St. Mary's and Stetson hospitals; died September 19, aged 82, of cardiovascular renal disease.

Jay Dow Shively, Clinton, Mo.; American Medical Missionary College, Battle Creek, Mich., and Chicago, 1900; died September 9, aged 77, of intestinal obstruction.

Robert Armstrong Smith, Ghent, Ohio; McGill University Faculty of Medicine, Montreal, Canada, 1897; veteran of the Spanish-American War; died in the People's Hospital, Akron, September 30, aged 78, of bronchopneumonia and cholelithiasis.

Wesley Munger Thomas ● Westville, Ind.; Chicago Homeopathic Medical College, 1895; formerly on the staffs of Ravenswood and St. Luke's hospitals in Chicago; died October 21, aged 80, of cerebral hemorrhage.

Albert Lycurgus Victor ● Washtucna, Wash.; Marion-Sims College of Medicine, St. Louis, 1899; member of the Oregon State Medical Association; died in a hospital at Pendleton, Ore., September 17, aged 79, of cerebral hemorrhage.

R. W. Waldrop ● Bessemer, Ala.; Louisville (Ky.) Medical College, 1896; fellow of the American College of Surgeons; owner and chief surgeon at the Bessemer General Hospital; died in Rochester, Minn., October 11, aged 74, of coronary occlusion.

Fernando A. Ward, Suffolk, Va.; Medical College of Virginia, Richmond, 1899; member of the American Medical Association; died October 9, aged 73, of Hodgkin's disease.

Frederick Stockton Watson ● Trenton, N. J.; Medico-Chirurgical College of Philadelphia, 1907; for many years on the staff of the Mercer Hospital, where he died September 15, aged 65, of coronary thrombosis.

Foreign Letters

PARIS

(From Our Regular Correspondent)

Nov. 20, 1948.

Treatment of Obstinate Eczema by Duodenal Intubation

P. Delore has presented to the Medical Society of the Lyons Hospital 21 cases of eczema treated by daily duodenal intubation. The patients had suffered for a long time from generalized eczema resisting all other treatment. The authors did not find any common stigma, but noted diabetes in 6 cases, obesity in 6 cases, slight hepatobiliary disorders in 3 cases and hypercholesterolemia in 1 and in 1 case hyperuricemia. They performed an average of twelve consecutive intubations and observed a remarkable sedative action on the pruritus in all cases. In 2 cases the eczema rapidly disappeared, and in 14 cases there was partial or temporary improvement. In 5 cases there was no improvement.

The author believes that the cholagogue effect of the intubation, and, through it, a favorable action on hepatic function explain the good results. He advocates this treatment in all resistant eczemas. H. Thiers, Racouchot and Tholot presented at the same meeting their observations on this treatment. They did duodenal intubation in order to find out latent vesical disorders by the study of the bile in a patient suffering from generalized exudative eczema. The bile was found to be normal or thick containing no formed elements, or microscopically slightly purulent, but with a negative culture. The results from repeated intubations were on the whole favorable. Complete recoveries were more infrequent but were obtained in patients with a slightly purulent bile; some complete failures were experienced; patients with a thick bile have been especially improved. In the discussion, Professor Gate showed interest in this new treatment of obstinate eczema.

Inquests on Cancer

In 1943, the National Institute of Hygiene (Cancer Section) set up a permanent enquiry on cancer in order to centralize all the documentation concerning this disease. It has just issued a statement showing that it succeeded in collecting, to date, 20 per cent of the cases occurring each year in France; 10,000 cases are taken up by anticancer centers, 2,000 cases by hospitals not specializing in the treatment of cancer, and 2,000 by the Social Security Service. Thanks to a specially organized social service, keeping in contact with patients has improved. In order to obtain the maximum of documentation the permanent enquiry has been extended to Africa. Interesting data have been collected on the comparison of cancer in white persons and in Negroes of other continents. For example, primitive cancer of the liver represents 35 per cent of recognized and histologically verified cancers among the Negroes of other continents, whereas in France it represents 0.5 per cent only. Conjunctival tumors appear to amount to 19.5 per cent, a proportion also much higher than in white persons. On the other hand, an enquiry on the eventual relation of cancer and heredity has been started. A French *département* (district) has been selected for the establishment of a genealogic index in which all the families will be inscribed and in which all births and deaths (those due to cancer being specified) are to be recorded; a minimum of three generations will be necessary to give information on this problem. A special bibliographic service, including all the world literature on cancer, has been organized.

ITALY

(From Our Regular Correspondent)

NAPLES, Nov. 15, 1948.

Nanism As An Aftermath of War

In the aftermath of diseases of the last war a noteworthy increase has been recorded in the incidence of Fröhlich's syndrome, and, above all, in the large number of dwarfs. Nanism, or any serious retardation of growth, often represents an enigma. Greenblatt, professor of endocrinology at the Georgia School of Medicine in Augusta, has divided nanism into the genetic, hypohormonal and hyperhormonal types and has subdivided the genetic type into proportionate and disproportionate; the hypohormonal type into hypothyroid, hypopituitary, hypogonadal and diabetic, and the hyperhormonal type into hypergonadal and hypercorticosteroid.

The anterohypophysial region is involved in the majority of cases of nanism. However, if detailed roentgenographic examination in various projections of the sella turcica or pituitary fossa is done, no specific changes may be observed in the majority of cases, except in cases of cysts with calcification. The same applies to the obscure relation between alimentation and nanism in cases of secondary infantilism. No doubt, deficiency of nutritive elements which are hormonic stimulants affects the stature of persons by delaying growth and development, as was demonstrated by results of food shortages during the last war, but there must be other factors which aggravate the effects of a deficient diet until it determines the anterohypophysial reaction. Whatever the mechanism may be, poor results follow present methods of treatment. The director of the Radiologic Institute of the University of Naples, Professor Mario Bertolotti, at a conference at the Medicophysical Academy of Florence and in another at the University of Naples, has demonstrated, that a large percentage of patients sent to him for endocrine disturbances attributed to the hypophysis, showed definite manifestations of serous meningitis rather than pituitary lesions. Serous meningitis was demonstrated in all forms of adiposogenital dystrophy, nanism and gigantism of genitals in the absence of any increase in body size.

MENINGITIS IN THE ABSENCE OF CLINICAL SIGNS

When members of the family of children with serous meningitis were interviewed, their answers always were negative with regard to an occasional infirmity of the meningeal type. The meningitis had a silent course, without any sign of meningism, or with signs which were definitely unappreciable (mild headache or temporary gastric disturbances). According to Bertolotti, this serous meningitis is responsible for inflammatory reactions of short duration which involve the entire diencephalohypophyseal system. These reactions are instrumental to a functional disturbance of the diencephalohypophyseal system, although they do not determine anatomic lesions which might cause deformation of the sella turcica or of the hypophysis demonstrable on roentgenographic examination. The signs of insufficiency may be followed by endocrinopathic repercussions of various importance: from nanism, which formerly has been defined generically as infantilism, to the syndromes of pseudo Fröhlich type.

What is the origin of this meningitis? Bertolotti has no doubts that it is an adenoid complication in the ethmoidal nasal region. Little by little the adenoid syndrome increases in children compelled to live inadequately with regard to dietetics and climate (effects of air warfare), until it assumes the form of a clinical entity which on roentgenographic examination may

be revealed as chronic posterior ethmoiditis or ethmoidosphenoiditis. The author has roentgenographic documents of hundreds of cases with manifestations of alterations concerning the structure of the sinuses, and in the near future there will be published a volume by a pupil of Bertolotti, who is the head of the most frequently quoted school of roentgenology of the skull in Italy.

PRACTICAL CONCLUSIONS

Bertolotti, who adheres to the clinicoradiologic management of the American School of Cushing, emphasizes that the ethmoiditis may escape detection, because it is submerged in the general picture of extensive adenoidism. In the controversies concerning the sequelae of the removal of the tonsils and adenoids in the genital sphere, the point of view of Bertolotti, which reveals a link between adenoidism as a sequela of ethmoiditis and anterohypophysial disturbances, deserves consideration. According to Bertolotti, it is necessary to act first concerning the latent serous meningitis in order to prevent the dangerous repercussions in the diencephalohypophyseal system. Lumbar puncture may be performed to attenuate the hypertension of the cerebrospinal fluid, or other therapeutic measures which the clinical surgeons may consider advisable may be resorted to. Treatment should be directed at the adenoidism and at the insidious manifestations of the ethmoiditis before it becomes chronic, involving the hormones. Bertolotti postulates continuous roentgenographic observations of the skull of all children with signs of adenoidism and mild manifestations of sinusitis and ethmoiditis. Lumbar puncture directed at the incipient meningitis may be much more effective than the customary opotherapeutic measures, particularly in cases in which there may be functional disturbances of the anterohypophysis or of the hypothalmus.

MADRID

(From Our Regular Correspondent)

Oct. 26, 1948.

Congress on Obstetrics and Gynecology

The Second Portuguese-Spanish Congress on Obstetrics and Gynecology was held in Lisbon May 2-8, 1948. Drs. F. Luque Beltrán of Madrid and Novais Esousa of Coimbra were presidents. The President of Portugal, the Embassador of Spain in Lisbon and the Ministers of State and of National Education of Portugal were present at the first session. The official topics on May 2 and 3 were: "The human embryo in the first few weeks," by Prof. Dr. Celestino da Costa; "History of Establishment of the Alfredo Costa Maternity," by Prof. Dr. Carhalho Dias; "Physiology of Menstruation," by Prof. Dr. C. Botella Llusia, of the Faculty of Medicine of Madrid, and "General Conception and Nomenclature of Changes in Menstruation," by Prof. Dr. M. Usandizaga Soraluce. The topics were interesting and the discussions which followed were important.

The official topics on May 4 were: "Chemotherapy and Antibiotic Therapy in Puerperal Infection," by Dr. Albertino de Barros; "The Stillborn from Obstetric and Legal Points of View," by Dr. Macau Moncanut; "Physiopathologic Aspects of Fetal Respiration," by Dr. Silva Nuñes; "Need of an International Concept for Determination of the Stillborn," by Dr. Amaral Pyrrait.

The whole session on May 5 was given to the problem of cancer. Official topics were: "Therapeutic Orientation on Carcinoma of Female Genital Organs," by Prof. Dr. J. García Orcoyen of the Faculty of Medicine of Madrid, and "Conduct Followed in Therapeutics of Cancer at the Instituto Portugues de Oncologia." There were also receptions and other festivities.

The congress resolved (1) to appoint a committee for uniformity of Nomenclature Concerning Menstrual Changes; (2) to request from the governments of both countries agreement on the Concept of the Stillborn; (3) to stimulate elevation of the educational level of midwives practicing in rural zones; (4) to increase the number of beds in obstetric hospitals for women of moderate economic means; (5) to establish and follow social and legal crusades against criminal abortion; (6) to give impulse and strength to social campaigns for investigation of and work against cancer, and (7) to hold the Third Spanish-Portuguese Congress at Barcelona, Spain, in 1950, with Prof. Dr. Lubiola of the Faculty of Medicine of Barcelona, the chairman, and Profs. Drs. Conill, Garriga Roca and Morais Ferias vice president, secretary and chairman of the Portuguese committee, respectively.

University Professors Appointed

The following professors have been appointed during this year: Professor of obstetrics and gynecology on the Faculty of Medicine of Madrid, Dr. J. Botella Llusia and on the Faculty of Valencia, Dr. F. Bonilla Marti; professor of physical therapy on the Faculty of Barcelona, Dr. V. Carulla Riera; professor of pediatrics and puericulture on the Faculty of Santiago, Dr. M. Suarez Perdiguero, and on the Faculty of Granada, Dr. A. Galdo Villegas; professors of descriptive anatomy and of anatomic technics on the Faculty of Salamanca, Drs. L. Jiménez Gonzales and J. L. Puente Domínguez. Professor of general histology and of pathologic anatomy on the Faculty of Santiago de Compostela, Dr. J. L. Arteta Algibez, and on the Faculty of Cadiz, Dr. D. Ferrer y Fernández de la Riva; professor of general pathology and clinical propedeutics on the Faculty of Santiago, Dr. A. Aznar Reig, and on the Faculty of Cadiz, Dr. F. Díaz González and professor of general and special physiology on the Faculty of Santiago, Dr. R. Domínguez Sánchez.

Lectures

Lectures were given at the Colegio Provincial de Médicos of Baleares in April by Prof. Dr. A. Pedro y Pons, on "Differential Diagnosis of Jaundice"; Prof. Dr. Piulachs, on "Mimmal Picture of Acute Abdomen"; Dr. P. Barcelo Torrents, on "Painful Shoulder"; Dr. A. Rocha, on "Preoperative Treatment of Diseases of Digestion"; Dr. C. Perez Vitoria, on "New Antithyroid Medications," and Dr. M. Estevez, on "Psychosomatic Medicine."

Congresses

The Seventh National Congress of Pediatrics will be held at Sevilla on May 1949, under the chairmanship of Dr. Saiz de los Terreros.

The second meeting of the Sociedad Internacional de Gastroenterología will be held at Spain in 1950, under the chairmanship of Dr. Gallart Mones of Barcelona.

Personals

Dr. L. García Tornell was recently appointed member of the Real Academia de Medicina of Barcelona. His speech of entrance to the Academia was on "Surgery in Spain in the Nineteenth Century."

Dr. P. Lain Entralgo, professor of the history of medicine at the University of Madrid, recently lectured in various South American countries. He was appointed honorary professor on the Faculty of Medicine of Chile and honorary member of the Society of Neurology and Psychiatry of Chile.

Professor Dr. G. Marañón, of Madrid, was recently appointed member of the Academia de las Ciencias at Lisbon.

Correspondence

SALICYLATE THERAPY IN RHEUMATIC FEVER

To the Editor:—I read with interest the editorial in THE JOURNAL, October 2, page 367, on the subject of "Salicylate Therapy in Rheumatic Fever." In this connection, you quote Coburn's work (Coburn, A. F.: Salicylate Therapy in Rheumatic Fever, *Bull. Johns Hopkins Hosp.*, Dec. 1943, pp. 435-464). If verified, such results would indicate a good method of treating rheumatic fever. However, an analysis of his results casts reasonable doubt on the validity of the conclusions. It is because this subject is such a vital one, and not in order to detract from the value of the work published, that the following considerations are brought forward.

1. In presenting the results, the criteria for determining cardiac damage are not described. The follow-up period seems to be too short to determine adequately the ultimate effect of the acute rheumatic episode or of the treatment, for pathologically demonstrable valvular heart disease may not appear until several years after the acute rheumatic attack. In reading the statement that in 16 of 19 patients with polycyclic attacks mitral valvular disease developed, one wonders how the presence of valvular disease can be noted so soon after the acute episode, unless there was previous valvular damage, for the preliminary group was studied in 1942, and the results published in 1943. Similarly, the statement that a patient escaped clinical signs of heart disease does not necessarily indicate the ultimate effect of the rheumatic episode in the more recently treated group.

2. The criteria for classifying the attacks as severe or mild are not presented. Further, the severity of such an attack need not be related to the subsequent appearance of rheumatic valvular heart disease, for there is a large group of patients with marked rheumatic valvular heart disease from whom no history of an acute rheumatic episode can be elicited.

3. Analysis of the results does not justify enthusiastic conclusions as to the efficacy of the method of treatment presented. In describing the treatment of 12 patients with infusions of 10 Gm. of sodium salicylate daily (preliminary group 3), it is stated that "without exception the sedimentation rates fell progressively and were normal or approaching normal after fourteen infusions." Study of the results listed in table 1 shows that, although all the sedimentation rates were approaching normal, by the fourteenth day of such treatment the sedimentation rates of only 2 patients were 19 or less, and those of 10 patients were 20 or more, of which 4 were 40 or more.

4. In the largest group, consisting of 58 patients, of whom 40 were selected to be reported, massive dose salicylate therapy in group 1 (20 patients) resulted in all of the sedimentation rates becoming normal in fourteen days or less. However, these patients had had elevated sedimentation rates for an average period of forty days before such treatment, thus making a total of sixty-three to forty-nine days before normal levels were reached. This does not seem significantly different from the results described in preliminary group 1, in which 19 patients with polycyclic attacks who were supposedly receiving inadequate salicylate dosage had elevated sedimentation rates for an average of nine weeks.

These points serve to emphasize the need for further observation and study of the effect of salicylate treatment of acute rheumatic fever before salicylates are recommended as a curative measure rather than as a means of achieving purely symptomatic relief.

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TOXICITY OF HEXACHLOROCYCLOHEXANE IN SCABIES

To the Editor:—Recent contributors to THE JOURNAL found hexachlorocyclohexane to be an effective and safe treatment for scabies even when spread on and rubbed into the entire cutaneous surface of the body in a vanishing cream base (Canon and McRae, THE JOURNAL, Oct. 23, pp. 557-560). Before this mode of treatment is accepted it seems that consideration should be given to the fact that recent experiments not cited by these authors show that both oily (Horton, Karel and Chadwick, *Science*, March 5, pp. 246-247) and aqueous (personal communication from Dr. Garner, U. S. Department of Agriculture Animal Research Department, Beltsville, Md., on work done by Department of Agriculture research workers at Kerrville, Texas) solutions of hexachlorocyclohexane can be fatal to rabbits and other animals by cutaneous absorption alone.

In addition to the possibility that hexachlorocyclohexane may be toxic on cutaneous absorption consideration should be given to its possible toxic effect on man and animals when used as an insecticide. This year for the first large scale use of hexachlorocyclohexane thousands of tons of insecticide dust containing this substance as its most potent component were dusted by plane or tractor on cotton fields throughout the South in an effort to control the boll weevil. My attention was first drawn to the possible toxic properties of this dust after the convulsive death of a child who lived but 100 yards from an insecticide mixing plant. This mixing plant in an effort to protect its workers had installed exhaust fans which blew out into the surrounding air spillage of dust incurred in the bagging process of the insecticide mixture containing hexachlorocyclohexane.

After the convulsive death of this child search of the literature revealed that hexachlorocyclohexane does characteristically cause a convulsive death when experimentally fed to (Furman, *J. Econ. Ent.*, vol. 40, p. 518, 1947) or injected into (*J. Pharmacol. & Exper. Therap.*, February, pp. 140-146) animals. It was noted also that, although there was widespread dusting of cotton fields throughout the South with this mixture containing hexachlorocyclohexane and although there was resultant inhalation of the mixture by thousands of animals and human beings, there is as yet no controlled inhalation experiment on hexachlorocyclohexane in the medical literature (a search for an article on inhalation was made by the staff at Army Medical Library, Washington, D. C.; one European report was found and no toxicity reported, but these animals were exposed for but a short period), nor does questioning of experts in public health research reveal that any such experiment is now being made (personal communications from executive heads of governmental and private agencies closely associated with insecticide research).

Further evidence of the toxicity of this chemical is seen in the fact that 6 rabbits placed at the aforementioned insecticide plant and exposed to the dust lost in the normal working process of the plant all died during the second week of exposure. In addition, a personal survey of farms in different areas of North and South Carolina revealed reports of convulsive death in cows, pigs, mules, dogs and chickens (e. g., 5 cows died at Lumber Ridge, N. C., 7 pigs at Clio, S. C., and 100 chickens at Maxton, N. C.) after this insecticide containing hexachlorocyclohexane had been dusted on nearby cotton fields from planes.

In conclusion, would it not seem that further work is indicated on hexachlorocyclohexane before it is to be considered adapted for unrestricted use either as an insecticide or as a cure for scabies?

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Medical Economics

HEALTH AND SOCIAL SECURITY

MORRIS FISHBEIN, M.D., Editor
The Journal of the American Medical Association

Fifteen years have passed since Harvey Cushing wrote one of his most important essays, entitled "Medicine at the Crossroads."[1] Now, in 1948, the forces of medicine are assembling at a point of decision which may well determine the nature and the freedom of medical practice for many years in the future.

The 80th Congress, which was harshly criticized by the President in his campaign speeches because of its failure to enact some legislation which he favored and for enacting other legislation which he did not favor, paid much attention to problems of health and medical care. Extensive hearings were held on both the Taft-Smith-Ball-Donnell bill, which proposed to advance medical science by the well established principle of federal grants to the individual states, and the Wagner-Murray-Dingell bill, which would establish a nationwide system of compulsory sickness insurance.

Few persons realize how greatly our federal government enters into the care of the sick under existing legislation. In 1948 the federal government assumed the total cost of approximately $6,000,000,000 for medical, hospital, educational and welfare needs of veterans. Benefits were paid to more than 2,000,000 persons under the old age and survivors' insurance program.

The 80th Congress passed a bill providing for increased cardiovascular research, improvement and expansion of heart disease detection and diagnostic services and training of workers in research and in matters relating to the diagnosis, prevention and treatment of heart diseases. For the year commencing July 1, 1948, the Congress voted $3,144,088 for this purpose.

The National Dental Research Act was passed for approaching the dental problem in a similar manner, and law authorizes an annual appropriation of $750,000 toward dentistry.

A further expansion of the national mental health program was approved, and grants-in-aid for community mental health services were increased to $3,550,000 annually. Research and training grants were increased to $2,000,000, and smaller increases for work of the Public Health Service in this field were approved.

The 80th Congress voted about $175,000,000 for the control of venereal diseases, tuberculosis control, general public health work, control of communicable diseases, the National Institute of Health, cancer research and control, a hospital construction program, the construction of a medical research center, maternal and child services and services for crippled children.

Other important bills, which were considered but not passed, included federal aid to the states in providing full time public health services, federal aid for school health services and for the treatment of physical and mental defects in conditions of school children, federal aid for providing various expensive drugs and medical services, federal aid for research and training in poliomyelitis and a bill to create a national science foundation.

Also reported favorably to the Senate was a bill to create a Department of Health, Education and Security to supersede the present Federal Security Agency. No action was taken on this bill because there should be available soon a report of a bipartisan commission under ex-President Herbert Hoover which is studying and preparing plans for reorganization of the federal government. This commission will recommend not only structural changes but will also make recommendations on functions of various departments in the light of their cost, their usefulness, their limitations and their curtailment or elimination.

The Social Security Act of the United States provides for cash indemnity to meet the hazards of old age and unemployment and for funds granted to the individual states to be applied in the field of health. The latest reorganization was that of 1946. The programs involved include old age and survivors' insurance, unemployment insurance and public assistance. The latter provides old age assistance, aid to dependent children and to the blind, maternal and child health services, services for crippled children and child welfare services. The benefits under the Act as far as old age is concerned are not available to large classes of workers, including agricultural labor, domestic service in private homes, local governments, employment by religious, charitable, educational and scientific organizations not for profit and similar groups. Railroad employment is covered by the Railroad Retirement Act. The unemployment insurance is administered by the states with federal cooperation.

Under the program for public assistance the federal grants are made to the states to aid them in giving financial assistance to certain groups of needy persons. The state plan must meet requirements set forth in the Social Security Act.

In June 1947 more than 4,000,000 persons were receiving public assistance, of whom 3,300,000 were on the program under the Social Security Act. The expenditures amounted to almost one and one-half billions of dollars.

For maternal and child health and welfare the Social Security Act authorizes federal grants to the states to extend and improve their health and welfare services for mothers and children, especially in rural areas suffering from economic distress. In 1946 the grants were $11,000,000 for maternal and child health services, $7,500,000 for services for crippled children and $3,500,000 for child welfare services. In addition, the states must supply $5,500,000. During 1946 medical services were given to 129,000 women at prenatal clinics and to 456,000 infants and preschool children at child health conferences. Medical health supervision was provided for 1,600,000 school children by state health authorities. Public health nursing service was given to 231,000 expectant mothers and to 952,000 infants and preschool children. Almost 4,000,000 children were immunized against infectious diseases, and 1,143,000 children received dental inspection. In addition to the $7,500,000 given by the federal government for services for crippled children, the states must supply $3,750,000. Thus the funds expended in the field of health under the Social Security Act approximate $35,000,000 to $40,000,000 annually.

The Senate Committee on Finance recently received its third report from its Advisory Council on Social Security under the chairmanship of Edward R. Stettinius Jr., this one covering public assistance. Over a period of twelve years public assistance programs ranged from a high of $472,000,000 in 1938 to $85,500,000 in 1944. During 1947 expenditures for general assistance from the state and local funds amounted to $164,000,000. Under present economic conditions the committee estimated that the annual cost to the federal government would approximate $75,000,000 for assistance payments and $15,000,000 for administrative expenses. Among the suggestions made by the Advisory Committee as concerned medical care, the committee recommended that the federal government should participate in payments made directly to agencies and persons providing medical care as well as in money payments to recipients. They suggest that the federal government should pay one-half the medical care costs incurred by the states above the regular maximums of $50 a month for the recipient but should not participate in medical costs above the regular maximums.

They also recommended that state public assistance agencies should be required to submit their plans to the Social Security Administration for its approval, setting forth the conditions under which medical needs will be met, the scope and standards of care, the methods of payment and the amount of compensation for medical care.

Most of the states are now financing the medical care they provide from state and local funds. Since the states with comparatively meager resources cannot spend funds without federal matching, these states provide little or nothing for medical care. Moreover, it is said that in almost all states the medical care provided under this program is inadequate.

One paragraph of the report merits emphasis. They suggest that medical care for assistance recipients should be provided under arrangements that afford the assistance agency flexibility in establishing policies and procedures. "It is frequently desirable to let recipients make their own arrangements for medical services. On the other hand, there are many circumstances in which the assistance agency finds it preferable to pay the doctor

1. Cushing, H.: Medicine at the Crossroads, J. A. M. A. **100**: 1567 (May 20) 1933.

or other supplier of medical care directly." Again they emphasize, "Choice could be made of the best way to make medical care available to a recipient in his particular situation."

The report indicates, "Recipients of old age assistance have an average age of 75 years and have great need of medical services." Like other persons of advanced age they are particularly subject to chronic diseases. One third of the recipients of medical care for dependent blind persons are 65 years of age or over. These persons have other infirmities besides blindness. About one fifth of the recipients are blind as a result of cataract, which, it is suggested, might have been corrected by surgical treatment. More than one tenth of the recipients suffer from glaucoma.

Another recommendation suggests that the federal government should participate in payments made to or for the care of old age assistance recipients living in public medical institutions other than mental hospitals. "To receive federal funds to assist old people in medical institutions under either public or private auspices," says the report, "a State should be required to establish and maintain adequate minimum standards for the facilities and for the care of persons living in these facilities. These standards should be subject to approval by the Social Security Administration." The Advisory Council feels that care for aged and chronically ill persons is a growing problem and in the opinion of the Council is a federal concern. Today more than 350,000 recipients of old age assistance are bedridden or so infirm as to need help in eating, dressing and getting about indoors. Some 50,000 of these are living in commercial boarding or nursing homes or private institutions, and many are getting unsatisfactory care.

Since the passage of the original Social Security Act in 1935 the number of persons aged 65 and over has increased from 8,000,000 to nearly 11,000,000. Moreover, it is estimated that another 25 years will double the number of persons over 65 years of age. Investigators found that needy persons without additional resources are allowed $50 a month. In Connecticut in 1946 the average cost of nursing home care for aged persons was $118 a month.

Another recommendation of the Advisory Council on social security suggests that a commission should be appointed to study current child health and welfare needs and to review the programs operating under title V of the Social Security Act, relating to maternal and child health services, services for crippled children and child welfare services. The Council recognizes that these problems can be approached from several different points of view. The question is asked, "Should necessary health and welfare services be provided to all children and mothers or should they be limited to those whose families cannot afford to pay for the services?" They ask, "Is the present scope of maternal and child health and welfare services sufficiently broad or should new services be instituted?" And then they inquire, "Should new or expanded services be supplied by governmental agencies, by voluntary agencies or by both acting together?"

The health needs which the Children's Bureau feels are most urgent are:

1. Inadequate health services for both mothers and children; these services are lacking in many areas, particularly in rural communities.

2. Rheumatic fever; some 500,000 children are suffering from rheumatic fever.

3. Premature birth; some 150,000 infants are born prematurely each year.

4. Lack of dental care; some 20,000,000 children are in urgent need of dental attention.

5. Cerebral palsy; between 100,000 and 160,000 children have cerebral palsy.

6. Physical and mental defects; many children of school age lack provision for medical examinations and for the correction of handicapping conditions found.

7. Inadequate supply of professional personnel; nearly all parts of the United States lack a sufficient number of pediatricians, public health nurses and medical social workers to provide adequate health services for children.

This then is the status of social security in the United States, particularly from the point of view of health, on the eve of the convening of a new Congress and the taking of office by a reelected president.

Strangely, an acceptable statement on the condition of health and medical care in the United States at this time is not easily available. Most sound of all of the statements thus far published was the report of the Brookings Institution to the Senate Committee headed by Senator Alexander Smith. Yet shortly after the publication of this report the propagandists for compulsory sickness insurance refused to accept its facts, figures and conclusions and issued a document in opposition. Presumably the report to the President by Oscar R. Ewing entitled "The Nation's Health," issued in September 1948 after a week of conferences in Washington, should offer an acceptable statement. Yet it comes far indeed from being anything resembling a scientific document. Those who understand the nature of these governmental performances were not astonished at the result. Almost from the first it was apparent that Mr. Ewing was stacking his executive committee. When that condition was corrected, Mr. Ewing made it clear that he would in any event recommend compulsory sickness insurance. What came forth was a shrewdly contrived document, designed to break down the confidence of the American people in their medical care and pointing repeatedly to compulsory sickness insurance as the cure for the misrepresentation that the document sets forth. A peculiar folly is the suggestion that every state should have a medical school and a medical center around the school. That type of broad generalization could have been made only by someone totally lacking in a knowledge of medical education and its problems. It will take far more than ten years to accomplish that objective.

The report says that a scant 20 per cent of our people are able to afford all the medical care they need—and this in a nation with the highest standard of living of any nation in the world. Who determines how much medical care people need? What kind of medical care meets the needs of the American people? We have in the United States some 200,000 physicians, 16,000 chiropractors and 7,000 or 8,000 osteopaths, with perhaps 15,000 or 20,000 more nondescript healers of every type from faith healing to the utilization of electric gadgets. How much could be saved by the elimination of this borderline quackery? Bear in mind that no other nation in the world is subject to the amount of medical quackery that we seem to tolerate and support.

The report says that 30 per cent of American families with incomes between $3,000 and $5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness. How many of these families go into debt to purchase motor cars, furs, jewelry or other luxury items? The cigaret bill of the nation rose from 10 billion cigarets in 1915 to 350 billion cigarets in 1945. Many an American family spends over $180 a year on tobacco. Certainly individual planning in a democracy is just as important as government planning. Many a family fails to plan for medical care, but finds itself quite efficient in planning for other purposes, like radio, television, motion pictures, football games and similar amusements. The bill for sports and pastimes in the United States far exceeds the bill for medical care. Yet Mr. Ewing comes to the ultimate conclusion in which he says, "I have reached the considered conclusion that more extensive and efficient nationwide planning is the only effective way to accomplish a significant betterment in national health."

When the last Congress adjourned, a committee was established to report in March 1949 on legislation in the field of medical care. No doubt additional hearings will be held, and conceivably the Congress may find a means to encourage federal aid to help in solving at least in part our medical problem.

Fundamental to every advance in the field of medical care is the quality of medical education. American medical education is today the best in the world. Medical education in the United States includes the voluntary contributions to medical teachings of great numbers of American physicians who recognize that the dissemination of medical knowledge to future generations is basic to the existence of the profession itself.

The statement has been made that we do not have enough medical manpower, enough health facilities or enough research. Medical manpower is basic to a wider extension of research. No doubt the Congress will eventually pass the National Science Foundation bill and thus increase the training of young men in qualified medical schools, but particularly in the basic sciences, which are today in serious need.

In England, following the adoption of the National Health Act which promised everyone in England free medical service and free hospitals, free eyeglasses and free teeth, as well as everything else free in the field of medicine, the service has been marked by utter inability of the doctors, the hospitals, the pharmacists or the dentists to meet the demands placed on them by a great rush of people who wanted perhaps simply to find out how the system works.

My personal observations in England led me to the opinion that the quality of medical service rendered under the National Health Act would never be satisfactory to the average American laborer or farmer. The greatest mistake that England made in adopting its National Health Act was its failure to realize that even moderately good functioning of such an act depends on adequate medical personnel and medical facilities. These England did not have. British politicians felt that any kind of medical care was better than no medical care. That is a hazardous hypothesis.

The American people, including leadership from all of the professions concerned in medicine, have been striving in recent years to develop a plan for distributing medical care suitable to the American free enterprise system. The growth of prepayment plans for hospitalization and for medical care has been phenomenal. At least 30,000,000 persons are now covered by hospitalization insurance under the Blue Cross plans, and commercial carriers have more than doubled their enrolment, giving protection against the costs of hospitalization in 1947 to 14,000,000 voluntary subscribers. In the years from 1944 through 1947 private group health and accident insurance increased from 7,000,000 to more than 14,000,000 persons. Simultaneously, physicians were organizing physician-sponsored prepayment medical and surgical care plans. Today there are some 70 such plans in operation, with a coverage of approximately 7,000,000 persons. Complete medical care programs by the end of 1947 covered more than 1,000,000 persons. No other country has ever developed such a voluntary coverage in such a period of time, and there is reason to believe that this system of coverage is far better suited to the conditions that prevail in the United States than would be any system under government control.

The problem of providing medical care wherever needed is not nearly as simple as many economists and political leaders would lead the people to believe. Again and again political leaders have denied that nationwide compulsory sickness insurance is socialized medicine. Yet the nations that embark on such programs move inevitably into a socialized state in which mines, banks, transportation and practically all public services become nationalized, private responsibility and ownership disappear, individual initiative is destroyed and the result is a socialized state. At the same time that many of our political leaders oppose communism they move toward communism by embracing socialism.

Nowhere else in the world are people as free from the fear of epidemic disease or from the danger of preventable death as in the United States. Obviously we have not yet reached perfection. Anyone familiar with the history of disease would state positively that mankind may never reach perfection in this regard. Disease itself is not static but constantly changing. One need only compare the leading causes of death in 1910 with those of today to know that in the short span of two generations there have been vast changes in our scientific approach to the problems of medical care.

We need no revolution to advance against disease at this tremendous rate of the past forty years, nor do we need a revolution to intensify our progress. The establishment of a compulsory sickness insurance system which would inevitably degrade and deteriorate the medical profession would represent a revolution and would with certainty deteriorate the quality of medical care rendered to our people. Once a nation has embarked on such a program, the ability to retrace the steps becomes less and less with every year that passes. As the years go by, the quality of medical education deteriorates. As the years go by, young men seek opportunity to enter other professions than medicine. Research fails to attract the type of men who in the past have given us the discoveries that have removed the fear of tuberculosis and pneumonia and of epidemic disease.

With what sophistic explanations will those who propose to tear down the great edifice of medical education, medical research and the quality of medical care that we have established in this country and to replace it with a bureaucratic civil servant type of medical care justify their conduct in the years to come?

Medical Motion Pictures

FILM REVIEWS

The following 16 mm., black and white, sound motion pictures were prepared in 1948 under the technical supervision of F. L. Fitzpatrick, Ph.D., Professor of Natural Sciences, Teachers College, Columbia University, New York. Produced by and procurable on rental or purchase from: United World Films, Inc., 445 Park Avenue, New York 22.

Paramecium. 390 feet, showing time ten minutes.

The anatomy and physiology of the paramecium including the phenomena of conjugation and of fission are well shown in this motion picture. The internal structure is demonstrated by illumination and magnification. The film is completely objective and well balanced in choice of material.

Amoeba. 275 feet, showing time seven minutes.

This film shows the living amoeba, demonstrating the behavior of the pseudopodia and its ingestion of prey, illustrating how the contents of a food vacuole are digested and absorbed.

The narrator does not always refer to what is being shown at the moment and occasionally contradicts what the audience sees. It must also be mentioned that the word "cyst," used by the narrator to mean a membranous wall, is misleading, since the word is ordinarily defined as a sac with fluid or semisolid contents. In every other respect the film is excellent.

The Life Cycle of Trout. 325 feet, showing time nine minutes.

The development of a fish is depicted beginning with the eggs as they lie on the bottom and with the sperm as it settles like a cloud through the water upon the eggs; however, the source from which the eggs or the sperm originated is not shown. The activity of the individual sperm cells and the peculiar movements on the surface of a developing egg are illustrated. The growth of the embryo is portrayed in an excellent manner and the cardiovascular system is well illustrated.

General Comment.—The terminology used by the narrator in these films can only be appreciated by adequately prepared high school or college classes; otherwise, for complete understanding, the films should be preceded either by reading or by other special preparation. These productions should be valuable material for courses in nursing education in which references to amoeba and paramecium are frequently made in courses in physiology in the absence of facilities for showing the living object. They would also supplement a program for sex education.

All three films are distinguished by a commendable pedagogical device; namely, a succinct recapitulation of the subject matter in the closing sentences of the narration. The photography and photomicrography are excellent throughout these films.

Removal of Intervertebral Discs by the Abdominal Extraperitoneal Route. 16 mm., color, sound, 400 feet, showing time twelve minutes. Prepared in 1948 by Paul H. Harmon, M.D., Oakland, Calif. Procurable on loan from the author, The Permanente Hospitals, Department of Orthopedic Surgery, Broadway and MacArthur Blvd., Oakland 11.

The operation portrayed in this motion picture is unique; however, its use is not justifiable because the more or less standard types of surgical procedures for the removal of intraspinal lesions employed by innumerable surgeons have given satisfactory results. The operative procedure illustrated does not enable the surgeon to visualize the porton of the interver-

tebral disk which is protruded and produces the patient's symptoms and signs. It probably would be easy to overlook loose intraspinal fragments of the disk. It would be impossible to remove an intraspinal neoplasm which had masqueraded as a protruded intervertebral disk, and if hemorrhage occurred in the spinal canal, it likely would not be recognized until gross neurologic signs developed. Then, a rather extensive laminectomy for removal of blood clot would be required. The abdominal incision cutting across muscle fibers and the nerves which supply the abdominal muscles would result in a weakness of the abdominal wall, if not actual hernia. Furthermore, there seems to be unjustifiable danger to the great vessels coursing anterior to the spinal column and to the sympathetic trunk. Although this type of procedure could be used for some protrusions of thoracic disks, such a surgical attack on thoracic disks is likely to carry a much higher morbidity and mortality rate than the usual laminectomy operation. The operation, of course, is not applicable to protrusions of cervical disks, and the posterior approach through the spinal canal which is applicable to disk lesions in the lumbar, thoracic and cervical regions should be, for the time being at least, the approach of choice.

Photography is very good.

Listening Eyes. 16 mm., color, sound, 700 feet (1 reel), showing time seventeen minutes. Prepared in 1948 for The John Tracy Clinic, Los Angeles, by the University of Southern California, Department of Cinema, under the sponsorship of Walt Disney Productions. Procurable on loan from: The John Tracy Clinic, 924 West Thirty-Seventh Street, Los Angeles 7.

This is an excellent demonstration of methods used to develop the deaf child mentally, physically, emotionally and socially, and also depicts the activities of sense training, speech reading and speech preparation. It shows the mother attending psychology and speech classes once a week observing and eventually taking a part in the teaching program for her child.

This motion picture is recommended for showing to pediatricians, otologists, general practitioners and medical students. It should also be suitable for parent-teachers' groups, boards of education, teachers of exceptional children, prospective teachers at universities and service organizations, to inform them that there is an institution which helps parents understand the problems of deafness and that handicapped children can be helped.

This is a well planned motion picture. The photography is excellent.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Food and Drug Acts: Use of Qualified Medical Witnesses to Establish Misbranding.—This was a consolidation for purposes of trial of four libel actions by the United States for the condemnation of quantities of a proprietary drug called "nue-ovo." The defendant intervened as claimant of the seized property and, from judgments of condemnation, appealed to the circuit court of appeals, ninth circuit.

The defendant, an Oregon corporation, has engaged in the manufacture, sale and distribution of, among others, a proprietary drug product known as "nue-ovo." The product is manufactured at Portland, Ore., and shipped to purchasers and distributors in most of the states west of the Mississippi River. The defendant's direct sales program involves extensive use of advertisements in daily and weekly newspapers and similar publications. The advertisements referred to are not, of course, part of the labeling. The libel alleges, however, that certain statements contained in circulars shipped with the product are false and misleading in that they represent and suggest and create in the mind of the reader thereof the impression that "nue-ovo" is effective in the treatment of arthritis, rheumatism, neuritis, sciatica and lumbago, whereas the article is not effective in the treatment of such conditions. One of the defendant's major contentions on appeal was that the trial court had erred in submitting the issues to the jury since every statement in the labeling as to the effectiveness of the product is a statement of opinion and at the conclusion of the case the record showed nothing more than a difference of opinion among qualified medical experts as to the effectiveness of the product.

Great reliance was placed, by the defendant, on a Supreme Court decision which was made about four years prior to the enactment of the original Food and Drugs Act in 1906. In that early case (*American School of Magnetic Healing v. McAnnulty*, 187 U. S. 94), the Supreme Court said that as the effectiveness of almost any particular method of treatment of disease is, to a more or less extent, a fruitful source of difference of opinion, even though the great majority may be of one way of thinking, the efficacy of any special method is certainly not a matter for the decision of the Postmaster General within these statutes relative to fraud. Unless the question may be reduced to one of fact, as distinguished from mere opinion, the decision continued, we think these statutes cannot be invoked for the purpose of stopping the delivery of mail matter. To illustrate some of the changes which have taken place in the law since the enactment of the Food and Drugs Act, however, the court of appeals said that in contrast to the meager technical facilities for the determination of medical questions possessed by the Postmaster General—at least at the time that the McAnnulty case was decided—the Federal Security Agency has at its disposal almost unlimited professional resources with which to carry out its investigations in the enforcement of the Federal Food, Drug and Cosmetic Act of 1938. This extensive professional implementation now authorized by the Food and Drug Act, said the court of appeals, was fully utilized in the case at bar.

Much of the government's evidence in the instant case consisted of "controlled clinical studies" conducted by eminently qualified physicians and surgeons. Dr. Frances Baker, Director of the Department of Physical Medicine at the University of California, whose professional qualifications appear to be highly impressive, testified at great length regarding a clinical study that she made in 1944 with the "nue-ovo" that contained cascara and licorice, but not vitamin B_1 and salicylate. The study was made on patients in the orthopedic clinic at the University of California Hospital. At the end of two months, 5 of the patients "were no better at all" and "one felt better." As the results of her studies, Dr. Baker testified that she thought that "nue-ovo" "offers us nothing that is of value in the treatment of arthritis." She expressed similar opinions as to "nue-ovo's" effectiveness in cases of lumbago, sciatica, neuritis and rheumatism and stated that the addition of sodium salicylate and vitamin B_1 in quantities found in one type of "nue-ovo" would not "give us any value whatever." Dr. John H. Wheeler, a practicing physician in Kansas City, Mo., and on the teaching staff of the University of Kansas, in 1944, at the request of the Food and Drug Administration in Kansas City, made a study of "nue-ovo" in the outpatient department of the University of Kansas. The type of "nue-ovo" that he used was also that containing cascara and licorice, without the vitamin B_1 and salicylates. Six patients were asked to continue the medicine for six weeks. Dr. Wheeler testified that the medicine had "no effect whatsoever" on 3 patients, and 2 patients stated that they "were of the opinion . . . that they were no worse." On the day of his return, the sixth patient "felt that he had definitely improved while taking his "nue-ovo," but "was complaining of some new pains involving both knees." This sixth patient, however, made that report ten months after starting the medication with "nue-ovo" and still had some of the six weeks' supply of the medicine left. On the basis of this experience and the experience of prior experiments in 1940, Dr. Wheeler was of the opinion that, with or without cascara, licorice or sodium salicylate or thiamine in the amount stipulated, "nue-ovo's" "effectiveness is nil" in the treatment of arthritis, rheumatism, lumbago, neuritis and sciatica. Dr. James M. Dille, professor of pharmacology and assistant dean of the School of Medicine of the University of Washington, while on the witness stand went down the list of ingredients of "nue-ovo" and categorically reported that scientific "investigation" by "doctors or pharmacologists" has shown that many of the ingredients have no "action" as drugs.

The testimony of experts that is based on tests or experiments made by them does not come within the ambit of the McAnnulty rule, said the court of appeals. It is generally agreed that testimony as to the consensus of medical opinion may be considered in drug-misbranding cases. In this circuit and elsewhere it has been held that expert testimony even in its broadest sense—i. e., where the witness has neither tested the product nor purports to report the consensus of medical opinion—is admissible on the question of therapeutic value. Altogether, the court concluded, there was ample evidence to support the verdict of the jury.

This, and other contentions of the defendant were accordingly overruled, and the judgment of condemnation was affirmed [Certiorari was denied by the Supreme Court of the United States.]—*Research Laboratories, Inc. v. United States, 167 F. (2d) 410 (1948).*

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS: *Parts I & II.* Various Centers, Feb., June and Sept. 1949. *Part II.* April, 1949. Exec. Sec., Mr. E. S. Elwood, 225 S. 15th St., Philadelphia 2, Pa.

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY, INC.: *Written.* July 15. Various locations. Final date for filing application is April 15. Sec., Dr. Curtiss B. Hickcox, 745 Fifth Avenue, New York 27.

AMERICAN BOARD OF INTERNAL MEDICINE: *Oral.* San Francisco, Feb. 8-10, 1949. New York City, March 23-25. Final date for filing application is Jan. 2. Philadelphia, June 1-3. Final date for filing application is Jan. 2. *Written.* Oct. 17, 1949. Final date for filing application is May 1. Asst. Sec.-Treas., Dr. W. A. Werrell, 1 W. Main St., Madison 3, Wis.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: *Oral.* Chicago, June 1949. Final date for filing application is Jan. 1949. Sec., Dr. W. J. German, 310 Cedar Street, New Haven, Conn.

AMERICAN BOARD OF OPHTHALMOLOGY: *Written,* Jan. 14. *Oral.* San Francisco, March 21-24; New York, June 11-15; St. Louis, Oct. 15-19; Boston, Dec. Sec., Dr. S. J. Beach, 56 Ivie Rd., Cape Cottage, Maine.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.: *Oral.* Chicago, May 8-14. Final date for filing application is April 1. Sec., Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6.

AMERICAN BOARD OF ORTHOPEDIC SURGERY: *Part I.* Various Centers, April and May. Final date for filing application is Dec. 31. Sec., Dr. Francis M. McKeever, 1136 W. 6th St., Los Angeles 14.

AMERICAN BOARD OF OTOLARYNGOLOGY: New York, May 11-14; Chicago, Oct. 4-7. Sec., Dr. D. M. Lierle, University Hospital, Iowa City.

AMERICAN BOARD OF PATHOLOGY: Boston, April. Final date for filing application is March 1. Sec., Dr. Robert A. Moore, 507 S. Euclid Ave., St. Louis 10, Mo.

AMERICAN BOARD OF PEDIATRICS: *Oral.* St. Louis, Feb. 18-20. Baltimore, May 7-9. Exec. Sec., Dr. John McK. Mitchell, 6 Cushman Rd., Rosemont, Pa.

AMERICAN BOARD OF PHYSICAL MEDICINE: Atlantic City, June 4-5. Final date for filing application is March 15. Sec., Dr. R. L. Bennett, 30 N. Michigan Blvd., Chicago.

AMERICAN BOARD OF PLASTIC SURGERY: Examinations are given in June and November of each year in the home town of applicants. Sec., Treas., Dr. Louis T. Byars, 400 Metropolitan Bldg., St. Louis, Mo.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY: *Oral.* May. Final date for filing application is Feb. 15. Sec., Dr. F. J. Braceland, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF SURGERY: *Written.* Various Centers, March 1949. Sec., Dr. J. S. Rodman, 225 S. 15th St., Philadelphia.

AMERICAN BOARD OF UROLOGY: Feb. 1950. Sec., Dr. Harry Culver, 7935 Sunnyside Road, Minneapolis 18, Minn.

BOARDS OF MEDICAL EXAMINERS

ALABAMA: *Examination.* Montgomery, June 28-30, 1949. Sec., Dr. D. G. Gill, 519 Dexter Ave., Montgomery.

ALASKA: * Juneau, March 1. Sec.-Treas., Dr. W. M. Whitehead, Box 140, Juneau.

ARKANSAS: * Little Rock, June 9-10. Sec., Dr. L. J. Kominsky, Texarkana. *Eclectic.* Little Rock, June 2-3. Sec., Dr. C. H. Young, 1415 Main St., Little Rock.

COLORADO: * Denver, Jan. 4-7. Final date for filing application is Dec. 18. Sec.-Treas., Dr. W. W. King, 831 Republic Bldg., Denver 2.

CONNECTICUT: * Hartford, March 8-9. Secretary to the Board, Dr. Creighton Barker, 258 Church Street, New Haven.

DELAWARE: *Examination,* Dover, Jan. 11-13. *Endorsement.* Jan. 20. Sec., Dr. J. S. McDaniel, 229 S. State St., Dover.

GEORGIA: *Examination.* June, Atlanta and Augusta. *Reciprocity,* Atlanta, June. Sec., Mr. R. C. Coleman, 111 State Capitol, Atlanta.

GUAM: *Endorsement.* Agana, Last Friday of each month. Sec., Capt. C. K. Youngkin, Dept. of Public Health, Guam, % F.P.O. San Francisco, Calif.

HAWAII: *Examination.* Honolulu, Jan. 10-13. Sec., Dr. S. E. Doolittle, 881 S. Hotel St., Honolulu 53.

IDAHO: Boise, Jan. 10-12. Dir., Bureau of Occupational Licenses, Miss Estella S. Mullner, State House, Boise.

ILLINOIS: Chicago, Jan. 11-13. Superintendent of Registration, Mr. Fred W. Ruegg, State House, Springfield.

INDIANA: *Examination.* Indianapolis, June. Sec., Board of Medical Registration and Examination, Dr. Paul R. Tindall, 416 K. of P. Bldg., Indianapolis.

MAINE: Portland, March 8-9. Sec., Dr. Adam P. Leighton, 192 State Street, Portland.

MASSACHUSETTS: *Examination.* Boston, March 8-11. Sec., Dr. George L. Schadt, 413 E. State House, Boston.

MINNESOTA: * Minneapolis, Jan. 18-20. Sec., Dr. J. F. DuBois, 230 Lowry Medical Arts Building, St. Paul.

MONTANA: Helena, April 4-6. Sec., Dr. O. G. Klein, First National Bank Building, Helena.

NEBRASKA: * *Examination.* Omaha, June. Dir., Bureau of Examining Boards, Mr. Oscar F. Humble, 1009 State Capitol Building, Lincoln 9.

NEVADA: Carson City, May 2. Sec., Dr. G. H. Ross, 112 N. Curry Street, Carson City.

NEW HAMPSHIRE: Concord, March 10. Sec., Board of Registration in Medicine, Dr. John S. Wheeler, 107 State House, Concord.

NEW JERSEY: *Examination.* Trenton, June 21-24. Sec., Dr. E. H. Hallinger, 28 West State Street, Trenton 8.

NEW MEXICO: Santa Fe, April 11-12. Sec., Dr. V. E. Berchtold, 141 Palace Ave., Santa Fe.

NEW YORK: *Examination.* Various Centers, Feb. 1-4. Sec., Dr. J. L. Lochner, Jr., 23 S. Pearl St., Education Bldg., Albany.

NORTH CAROLINA: *Endorsement.* Raleigh, Jan. 17. Sec., Dr. Ivan M. Procter, 226 Hillsboro St., Raleigh.

NORTH DAKOTA: *Examination.* Grand Forks, Jan. 4-7. Act. Sec., Dr. C. J. Glaspel, Grafton.

OREGON: * *Examination.* Jan. 5-7. *Endorsement.* Jan. 21-22. Final date for filing application is Jan. 3. Exec. Sec., Mr. Howard I. Bobbitt, 608 Failing Bldg., Portland.

PENNSYLVANIA: *Examination.* Philadelphia, Jan., 1949. Act. Sec., Mrs. M. G. Steiner, 351 Education Bldg., Harrisburg.

PUERTO RICO: *Examination.* Santurce, March 1. Sec., Mr. Luis Cueto Coll, Box 3717, Santurce.

RHODE ISLAND: * *Examination.* Providence, Jan. 6-7. Chief, Mr. Thomas B. Casey, 366 State Office Building, Providence.

SOUTH DAKOTA: * Pierre, Jan. 18-19. Sec., Dr. G. J. Van Heuvelen, Capitol Bldg., Pierre.

TEXAS: *Examination.* Austin, June 16-18. Sec., Dr. M. H. Crabb, 209 Medical Arts Bldg., Fort Worth 2.

UTAH: *Examination.* Salt Lake City, July. Sec., Dept. of Registration, Miss Rena B. Loomis, 324 State Capitol Bldg., Salt Lake City.

VERMONT: *Examination.* Burlington, Feb. 3-5. Sec., Dr. F. J. Lawliss, Richford.

WASHINGTON: * Seattle, Jan. Sec., Dept. of Licenses, Miss Virginia Wotherspoon, Olympia.

WEST VIRGINIA: Charleston, Jan. 3-5. Sec., Public Health Council, Dr. N. H. Dyer, Capitol Bldg., Charleston 5.

WISCONSIN: * Madison, Jan. 11-13, 1949. Sec., Dr. C. A. Dawson, Tremont Bldg., River Falls, Wis.

WYOMING: *Examination.* Cheyenne, Feb. 7. Sec., Dr. Franklin D. Yoder, Cheyenne.

* Basic Science Certificate required.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

ALASKA: Juneau, Feb. 21-26. Sec.-Treas., Dr. C. Earl Albrecht, Box 1931, Juneau.

CONNECTICUT: New Haven, Feb. 12. Exec. Asst., State Board of Healing Arts, Miss Mary G. Reynolds, 110 Whitney Ave., New Haven 10.

DISTRICT OF COLUMBIA: *Examination.* Washington, April 18-19. Sec., Dr. George C. Ruhland, 4130 Municipal Bldg., East, Washington.

FLORIDA: *Examination.* Gainesville, June 11. Sec., Mr. M. W. Emmel, University of Florida, Gainesville.

IOWA: *Examination.* Des Moines, Jan. 11. Sec., Dr. Ben H. Peterson, Coe College, Cedar Rapids.

MICHIGAN: *Examination.* Ann Arbor & Detroit, Jan. 14-15. Sec., Miss Eloise LeBeau, 101 N. Walnut St., Lansing.

MINNESOTA: *Examination.* Jan. 4-5, April, June and Oct. Sec.-Treas., Dr. Raymond N. Bieter, 103 Millard Hall, Univ. of Minnesota, Minneapolis.

OKLAHOMA: Spring of 1949. Sec., Dr. Clinton Gallaher, 813 Braniff Bldg., Oklahoma City.

RHODE ISLAND: *Examination.* Providence, Feb. 9. Chief, Mr. Thomas B. Casey, 366 State Office Building, Providence.

TENNESSEE: *Examination.* Memphis, Dec. 30-31. Sec., Dr. O. W. Hyman, 874 Union Avenue, Memphis 3.

WASHINGTON: Seattle, Jan. Sec., Dept. of Licenses, Miss Virginia Wotherspoon, Olympia.

WISCONSIN: Madison, April 2.. Milwaukee, June 4. Sec., Prof. W. H. Barber, Ripon College, Ripon.

POSTGRADUATE CONTINUATION COURSES FOR PHYSICIANS

Compiled by the Council on Medical Education and Hospitals for the Period January 1, 1949 to July 15, 1949

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Postgraduate Courses for Practicing Physicians—Jan. 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	ALLERGY		
American Academy of Allergy and University of Georgia Medical School, Augusta	Orientation Course in Allergy	5 days, March 7-11, 1949	$ 50.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago	Allergy, One Month Personal Course in Allergy	1 month, full time, first of every month	200.00
	Part Time Personal Course in Allergy and Related Conditions	10 weeks, April 20, part time, one day each week	125.00
	Six Month Personal Course in Allergy	6 months, full time, by appointment	500.00
University of Michigan Medical School, Department of Postgraduate Medicine, Ann Arbor At: University Hospital, Ann Arbor	Allergy	5 days, April 18-22, 1949	30.00
Wayne University College of Medicine, 1516 St. Antoine St., Detroit, Mich. At: City of Detroit Receiving Hospital	Allergy Clinic and Conference	8 months, part time, March 21-June 18, 1949	25.00
Joint Committee on Post-Graduate Education, Long Island College of Medicine, Medical Society of the County of Kings, 1313 Bedford Ave., Brooklyn At: Beth El Hospital At: Kings County Hospital	Allergy (I) Allergy (II)	8 weeks, part time, begins April 1949	30.00 20.00
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Medicine PM 36, Allergy	2 months, part time, once a week, Jan. 25-March 28, 1949	40.00
New York Medical College, Flower and Fifth Avenue Hospitals, 29 E. 106th St., New York	Allergy	2 months, part time, Tuesday mornings, arranged	50.00
New York University-Bellevue Medical Center, 477 First Ave., New York	A-302, Allergy	Jan. 7-Feb. 5, part time, Friday afternoons	25.00
	B-331, Allergy	3 weeks, full time, March 7-25, 1949	200.00
The American College of Physicians, 4200 Pine St., Philadelphia 4 At: Haddon Hall Hotel, Atlantic City, N. J.	Diseases Caused by Immune Mechanisms	1 week, full time, April 28-May 1, 1949	30.00 60.00
The Thomas Clinic, Richmond, Va.	Course of Training in Clinical Allergy	12 months, full time, January 1 and July 1 each year	None
	ANATOMY		
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago	Part Time Personal Course in Anatomy of the Extremities on the Cadaver	1 day each week for ten weeks, March 16	125.00
	Part Time Course in Surgical Anatomy on the Cadaver	1 day each for ten weeks, March 17	125.00
University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12	Dissection (essentially a review dissection without didactic instruction)	3 months, at physician's own choosing of time when material is available	Arranged
University of Maryland School of Medicine, Baltimore	General Anatomy "A" Surgical Anatomy "B"	Arranged 15 weeks, 2 days 1 week, 3 hours 1 day, Jan 26-June 4, 1949	Arranged 150.00
Harvard Medical School, 25 Shattuck St., Boston	Surgical Anatomy	54 days, May 2-June 24, 1949	200.00
Tufts College Medical School Postgraduate Division, 30 Bennet St., Boston 11 At: Zinkind Research Laboratories	Surgical Anatomy [18]	8 weeks, part time, March 7-April 30, 1949	200.00 [3] 5.00 [4]
University of Michigan Medical School Department of Postgraduate Medicine, Ann Arbor At: East Medical Building, Ann Arbor	Anatomy	16 days, Feb. 10-May 26, 1949	40.00
Wayne University College of Medicine 1512 Antoine St., Detroit 26	Surgical Anatomy	24 weeks, March 21-June 18, 1949	33.00 [3]
	Advanced Dissection (Trunk, Head and Neck, Back and Extremities) (Female Pelvis)	1 afternoon, March 21-June 18, 1949	50.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—Jan. 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	ANATOMY—Continued		
Cornell University Medical College, 1300 York Ave., New York 12	Course in Surgical Anatomy	4 weeks, May 31, 1949-June 25, 1949	200.00
New York Medical College, Flower and Fifth Avenue Hospital, 20 East 106th St., New York	Applied Anatomy for the General Surgeon	Approximately 250 hours, arranged	375.00
	Anatomy of the Abdomen	100 hours, to be arranged	150.00
	Anatomy of the Thorax	100 hours, to be arranged	150.00
New York Polyclinic Medical School, 341-353 W. 50th St., New York 19	Head and neck dissection	6 weeks, part time, arranged	150.00
New York Post-Graduate Medical School, 303 E. 20th St., New York 3	A-241, Surgical Anatomy as Applied to Operative Gynecology (Cadaver) [13]	12 sessions, Tues., Thurs. and Sat., 11 a.m.-12:30 p.m.; Feb. 1-March 1, 1949 and April 5-May 7, 1949	200.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	C-1605, Anatomy of the Abdomen	Part time	
		12 weeks, 5 days a week, 4 hours daily	150.00
		16 weeks, 5 days a week, 4 hours daily	200.00
		8 weeks, 5 days a week, 6 hours daily January-June 1949	225.00
	C-1604 (A), Anatomy of the Female Pelvis	Part time, 12 weeks, 5 days a week, 4 hours daily, January-June 1949	150.00
	C-1603, Anatomy of the Head and Neck	Part time	
		12 weeks, 5 days a week, 4 hours daily	150.00
		16 weeks, 5 days a week, 4 hours daily	200.00
		8 weeks, 5 days a week, 6 hours daily January through June	225.00
	C-1604 (B), Anatomy of the Male Pelvis	Part time, 12 weeks, 5 days a week, 4 hours daily, January-June 1949	150.00
	C-1635, Anatomy of the Musculoskeletal System	Part time	
		12 weeks, 5 days a week, 4 hours daily	150.00
		16 weeks, 5 days a week, 4 hours daily January-June 1949	200.00
	C-1602, Anatomy of the Thorax and its Viscera	Part time, 12 weeks, 5 days a week, 4 hours daily, January-June 1949	150.00
	C-1606, General Anatomy	Part time, 8 weeks, 5 days a week, 3 hours daily (mornings), January-June 1949	150.00
School of Medicine, Western Reserve University, 2101 Adelbert Rd., Cleveland 6	Postgraduate Applied Anatomy	5 afternoons weekly for 2 to 6 months, January-April 30, 1949, may start at beginning of each month	70.00 [8]
	ANESTHESIOLOGY		
The Colorado State Medical Society, Colorado State and Denver Society of Anesthesiologists At: The University of Colorado Medical Center, 4200 E. 9th Ave., Denver 7	General Practitioners on the Techniques and Practice of Anesthesiology	4 days, full time, Jan. 12-15, 1949	20.00 [9] 5.00 [4]
The George Washington University School of Medicine and Hospital, 1335 H St. N.W., Washington 5, D. C.	Anesthesiology	1 week, full time, Feb. 28-March 4, 1949	50.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	One Month Practical Course in Inhalation Anesthesia, including Ether and Nitrous Oxide	1 month, full time, available first of every month	125.00
	One Month Practical Course in Inhalation Anesthesia, including Ether, Nitrous Oxide, Ethylene and Cyclopropane	1 month, full time, available first of every month	200.00
	Two Weeks Practical Course in Spinal Anesthesia and Intravenous Anesthesia	2 weeks, full time, available every two weeks	150.00
	Two Weeks Practical Course in Endotracheal Anesthesia	2 weeks, full time, available every two weeks	150.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 East 106th St., New York	Applied Anatomy for the Anesthetist	125 hours, to be arranged	275.00
	Clinical Anesthesiology	3 months, full time, to be arranged	200.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Anesthesia	3 months, full time, Jan. 3, 1949; April 4, 1949	300.00
	Applied Anesthesia	3 months, full time, April 1, 1949	300.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 1st Ave., New York 16	B-942, Anesthesia	Full time, two weeks January-June	125.00 [7] 65.00 [8]
	B-943, Regional Anesthesia	2 weeks, full time, Monday through Friday, 9-5 p.m., Jan. 3-Jan.14, 1949; May 2-May 13, 1949	200.00
	B-944, Anesthesiology	2 weeks, full time, Monday through Friday, 9-5 p.m., April 11-April 23, 1949	150.00
Graduate School of Medicine, University of Pennsylvania, 237 Medical Laboratories, Philadelphia 4 At: Graduate Hospital and Private Offices	Segmental Neuralgias; Relief by Regional Anesthesia [15]	3 weeks (48 hours), February 1949-May 1949; monthly	300.00
	ARTHRITIS		
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Jewish Hospital	Arthritis	8 weeks, part time, beginning April 1949	30.00
New York University-Bellevue Medical Center Postgraduate Medical School, 477 First Ave., New York 16	B-330, Arthritis and Allied Rheumatic Disorders	5 days, full time, March 7-11, 1949	35.00
	A-301, Arthritis and Allied Rheumatic Disorders	Part time, Tuesday 9-12 p.m., Jan. 4-Feb. 15, 1949	45.00
	A-370, Arthritis and Rheumatic Disorders	6 weeks, part time, Mon., Wed., Thurs., 9-12 p.m., Jan. 3-Feb. 10, 1949	100.00
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Pratt Diagnostic Hospital	Rheumatic Diseases	5 days, full time, March 21-25, 1949	40.00 [9] 5.00 [4]
	BACTERIOLOGY		
Wayne University College of Medicine, 1312 Antoine St., Detroit 26	Antibiotic Substances	1 hour/week, March 21-June 18, 1949	15.00
	Immunology and Virology	1 afternoon/week, March 21-June 18, 1949	35.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 East 106th St., New York	Parasitology	1 afternoon/week, March 21-June 18, 1949	35.00
	Bacteriology	3 months, half time, to be arranged	100.00
	Parasitology	6 weeks, half time, to be arranged	75.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 1st Ave., New York 16	C-109, Bacteriology	16 weeks, part time, Monday 2-4 p.m., Feb. 28-June 13, 1949	75.00
	A-110, Clinical Bacteriology and Serology	Part time, Monday through Saturday 9 a.m.-12 p.m., Feb. 1-28, 1949	100.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Practical Laboratory Instruction in Bacteriology	Arranged	Arranged
	BASIC SCIENCES		
University of Michigan Medical School, Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor At: University Hospital, Ann Arbor	Application of the Basic Sciences to Clinical Medicine	1 month, Jan. 3-29, 1949	100.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—Jan. 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
BASIC SCIENCES—Continued			
Center for Continuation Study, University of Minnesota, Minneapolis 14	The Basic Sciences and Their Clinical Correlation	11 weeks, Jan. 4-March 19, 1949	150.00 [8] 11.15 [4]
New York Medical College, Flower and Fifth Avenue Hospitals, 99 E. 106th St., New York	Basic Sciences, Pathology related to Various Specialties	3 months to 1 year, full time, arranged	300.00 to 600.00 [10]
	Basic Sciences, Pathology related to Various Specialties	4-5 weeks, full time, arranged	300.00
University of South Dakota School of Medicine, Vermillion, S. D.	Clinical Considerations of Biochemistry, Applied Pathology, Clinical Applications of Physiology, Applied Anatomy, Clinical Applications to Pharmacology, Applied Bacteriology	3-6 months, any time	None
Southwestern Medical College of the Southwestern Medical Foundation, 2211 Oak Lawn Ave., Dallas 4, Texas	Individual Review in Basic Sciences	Part or full time, arranged	25.00 [10]
University of Wisconsin Medical School, 418 N. Randall St., Madison	The Basic Sciences	Semester basis, Feb. 7-18, 1949	100.00 [12]
BIOCHEMISTRY			
Baylor University College of Medicine, 809 Lincoln Ave., Houston, Texas	Seminar in Clinical Biochemistry	10 2-hour seminars, every third or fourth week, January-May 1949	Arranged
CARDIOVASCULAR DISEASE			
University Extension (Medical Extension), University of California, 605 Hilgard Ave., Los Angeles 24	Cardiology	5 days, full time, Jan. 31-Feb. 4, 1949	To be announced
Yale University School of Medicine and Connecticut State Medical Society, 323 Cedar St., New Haven 11, and 256 Church St., New Haven 10 At: Yale University School of Medicine, 333 Cedar St., New Haven 11	Medicine 200, Cardiovascular Disease	12 sessions, March 10-May 26, 1949	45.00
George Washington University School of Medicine, 1335 H St., N.W., Washington, D. C.	Cardiovascular Diseases	2 weeks, full time, April 25-May 6, 1949	100.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Personal Course in Cardiovascular Diseases	1 day each week for 10 weeks, April 13	80.00
	Part time Personal Course in Heart Disease and Electrocardiography	1 day each week for 10 weeks, February 23	125.00
	Four week Course in Electrocardiography and Heart Disease	4 weeks, to be announced	175.00
	Two week Personal Course in Electrocardiography and Heart Diseases	2 weeks, July 18	150.00
	Part time Course in Surgical Aspects of Peripheral Vascular Disease	1 day each week for 5 weeks, March 23	60.00
Harvard Medical School, 25 Shattuck St., Boston 25 At: Boston City Hospital, Boston	Cardiology (1)	3½ months, daily all day except Saturday afternoons, Jan. 31-May 14, 1949	500.00
At: Massachusetts General Hospital At: Peter Bent Brigham Hospital	Cardiovascular Disease Clinical Heart Disease	12 months, daily, April 1, 1949-March 1950 1 month, full time, probably in July 1949	800.00 150.00
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Pratt Diagnostic Hospital	Cardiology	5 days, full time, April 4-8, 1949	60.00 [8] 5.00 [4]
Michigan State Medical Society, 2020 Olds Tower, Lansing 8, Mich. At: Book Cadillac Hotel, Detroit	Heart and Rheumatic Fever	1 day, March 26, 1949	None
University of Michigan Medical School, Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich. At: University Hospital, Ann Arbor	Diseases of the Heart	5 days, April 4-8, 1949	30.00
Minnesota Heart Association At: University of Minnesota Center for Continuation Study, Minneapolis 14	Cardiovascular Diseases	2 days, Feb. 14 and 15, 1949	To be announced
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Beth El Hospital	Peripheral Vascular Diseases (I)	10 weeks, part time, beginning April 1949	20.00
At: Coney Island Hospital At: Jewish Hospital	Peripheral Vascular Diseases (III)	8 weeks, part time, beginning April 1949	20.00
	Peripheral Vascular Diseases (II)	5 weeks, part time, beginning April 1949	20.00
	Hypertension and Nephritis	8 weeks, part time, beginning April 1949	20.00
Columbia University, 630 W. 168th St., New York 32 At: Montefiore Hospital	Medicine, PM 61-B, Advanced Cardiology	4 months, once a week, three hours, Feb. 1, 1949-June 6, 1949	250.00
At: Mount Sinai Hospital	Medicine, PM 45, Bedside Diagnosis and Treatment of Heart Disease with Special Emphasis on Measurements of the Circulatory	2 months, once a week, 2 hours, Jan. 10, 1949-March 14, 1949	45.00
	Cardiovascular Diseases (Medicine PM-31)	2 months, part time, Jan. 25-March 24, 1949	125.00
New York Medical College, Flower and Fifth Avenue Hospitals, 99 E. 106th St., New York City	Cardiology	20 successive Wednesdays, 9-11:30, May begin any Wednesday except during July and August	150.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Diagnosis and Treatment of Diseases of the Heart	3 weeks, arranged, part time, arranged	75.00
New York University-Bellevue Medical Center, Post-Graduate Medical School, 477 1st Ave., New York 16 At: Beth Israel Hospital	A-37, Cardiovascular Diseases	12 weeks, part time, Jan. 6-March 24, 1949; March 31-June 16, 1949	50.00
	A-319, Peripheral Vascular Diseases	Part time, Tuesday, 2 p.m.-4 p.m. Jan. 4-Feb. 15, 1949	30.00
New York University-Bellevue Medical Center, Post-Graduate Medical School, 477 1st Ave., New York 16	B-340, Peripheral Vascular Diseases	Full time, five days duration, March 21-25, 1949	55.00
	B-349, Cardiology	Full time, 4 weeks duration, May 2-27, 1949	175.00
	A-363, Cardiology	Part time, Monday, 2 p.m.-5 p.m., Jan. 3-Feb. 21, 1949	45.00
St. Francis Sanatorium for Cardiac Children, Roslyn, N. Y.	Comprehensive Postgraduate Course in Rheumatic Fever and Rheumatic Heart Disease	2 weeks, full time, June 1-14, 1949	75.00
The American College of Physicians, 4200 Pine St., Philadelphia 4 At: Philadelphia General Hospital, Philadelphia	Cardiology	1 week, full time, to be announced, tentative date May 2-7, 1949	30.00 [1] 60.00 [2]
Graduate School of Medicine, University of Pennsylvania, 237 Medical Laboratories, Philadelphia 4	Cardiology	8 consecutive Thursdays (48 hours total) to start 1st Thursday of January and April 1949	80.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—Jan. 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
CHEST DISEASES			
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	Bronchiectasis	2 periods, 6 hours, beginning March 6, 1949; Mondays, 7:30-9:30 p.m.	15.00
George Washington University School of Medicine, 1335 H St., N.W., Washington, D. C.	Thoracic Diseases	1 week, full time, April 18-22, 1949	50.00
University of Florida, Department of Medicine, Graduate School, 2653 Riverside Ave., Jacksonville, Fla. At: Orlando, Florida	Tuberculosis Seminar	3 days, Jan. 5-7, 1949	Undetermined
American College of Chest Physicians, Pennsylvania Chapter and the Laennec Society, 500 N. Dearborn St., Chicago 10 At: Philadelphia	Postgraduate Course in Diseases of the Chest	1 week, full time, Feb. 28, 1949-March 5, 1949	Undetermined
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Personal Course in Technic of Physical Examination and Diagnosis of the Chest	1 day each week for 8 weeks, April 13	60.00
Indiana University School of Medicine and the American Trudeau Society, 1040 W. Michigan St., Indianapolis 7 At: Indiana University Medical Center, Indianapolis, Ind.	Postgraduate Course in Thoracic Disease	5 days, full time, March 14-18, 1949, inclusive	50.00
American Trudeau Society; St. Louis University School of Medicine, 1402 S. Grand Blvd., St. Louis 4; Missouri State Medical Association, 634 N. Grand Blvd., St. Louis 3	Postgraduate Course in Pulmonary Disease for General Practitioners	3 days, Jan. 17-19, 1949	25.00
American Trudeau Society, 1790 Broadway, New York 19; Emory University School of Medicine, 104 Physiology Bldg., Emory University, Ga. At: Atlanta, Ga.	Postgraduate Course in Pulmonary Diseases	5½ days, April 4-9, 1949	50.00
American Trudeau Society, Medical Section, National Tuberculosis Association, 1790 Broadway, New York 19; Tulane University of Louisiana School of Medicine and Louisiana State University, 1430 Tulane Ave., New Orleans 12 At: New Orleans, La.	Postgraduate Course in Pulmonary Diseases	2 weeks, March 13-26, 1949	100.00
American Trudeau Society, Medical Section, National Tuberculosis Association, 1790 Broadway, New York 19; Indiana University Medical School, 1040 W. Michigan St., Indianapolis 7 At: Indianapolis, Ind.	Postgraduate Course in Pulmonary Diseases	5½ days, March 7-12, 1949	50.00
Columbia University, 630 W. 168th St., New York 32 At: Columbia-Presbyterian Medical Center	Medicine PM-1, Physiologic Therapy in Broncho-Pulmonary Diseases	5 days, full time, Jan. 24-29, 1949	40.00
At: Montefiore Hospital	Medicine PM-63, Diseases of the Chest	4½ months, once a week, 2½ hours, Jan. 7, 1949-May 20, 1949	100.00
At: Mount Sinai Hospital	Diseases of the Chest (Medicine PM-37)	2 months, once a week, 3 hours, Jan. 29-March 28, 1949	60.00
American Trudeau Society, Medical Section, National Tuberculosis Association, 1790 Broadway, New York 19; College of Medical Evangelists and University of Southern California School of Medicine, Boyle and Michigan Aves., Los Angeles 33, and 3551 University Ave., Los Angeles 7 At: Los Angeles, Calif.	Postgraduate Course in Pulmonary Diseases	5 days, Jan. 25-29, 1949	50.00
New York Medical College, Flower and Fifth Avenue Hospitals, 26 East 105th St., New York City At: New York City Municipal Sanatorium, Otisville, N. Y.	Pulmonary Tuberculosis	3 weeks, full time	175.00 [20]
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 1st Ave., New York 16	A-308, Acute and Chronic Diseases of Chest	Part time, Thursdays, 9 a.m.-12 p.m., Jan. 6-Feb. 24, 1949	45.00
	B-335, Acute and Chronic Pulmonary Diseases	Full time, 5 day duration, May 2-6, 1949	55.00
Temple University School of Medicine, Philadelphia 40	Bronchology and Esophagology	2 weeks, Feb. 7-18, 1949	250.00
DERMATOLOGY AND SYPHILOLOGY			
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	Dermatology	12 periods, 18 hours, begins Jan. 4, 1949, Tuesdays 6-9:30 p.m.	40.00
University Extension in cooperation with University of California Medical School, San Francisco and Los Angeles, Calif. At: Quonset Hut Conference Room, General Medical and Surgical Hospital, V. A. Center, Wilshire and Sawtelle Blvds., Los Angeles 25	Dermatology in Internal Medicine	8 meetings of 2 hours, January 3rd weekly through February 21	25.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Clinical Course in Dermatology	2 weeks or one month, begins every Monday except when no. 2 in session	75.00 [9]
	Two week Course in Dermatology	2 weeks, April 18, June 13	100.00
	Twelve month Clinical Course in Dermatology	12 months, by appointment	1,000.00
Harvard Medical School Courses for Graduates, 25 Shattuck St., Boston 15 At: Massachusetts General Hospital	Dermatology	1 month, half, February, March, April, May 1949	75.00
	Dermatology 2	Monthly, daily, all day, except Saturday afternoons, monthly, February to May 1949	125.00
	Dermatology and Syphilology	12 months, full time, April 1, 1949-March 1950	750.00
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Boston City Hospital	Dermatology II	5 days, full time, April 11-15, 1949	40.00 [9] 5.00 [4]
Wayne University College of Medicine, 1312 Antoine St., Detroit 26 At: Receiving Hospital At: Social Hygiene Clinic	Dermatology Seminar	2 hours/week, March 21-June 13, 1949	15.00
University of Minnesota Center for Continuation Study, Minneapolis 14	Conference on Venereal Diseases	1½ hours/week, March 21-June 13, 1949	15.00
	Dermatology	2 days, May 16 and 17, 1949	To be announced
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Venereal and Skin Diseases (Medicine PM-49)	6 weeks, part time, Jan. 26-March 11, 1949	30.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Dermatology and Syphilology	6 weeks, part time, and 3 months, part time, Jan. 3, April 4, 1949	100.00 300.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-1210, Seminar in Dermatological Histopathology [18]	5 days duration, full time, May 9-13, 1949	75.00
	B-1230, Symposium on Dermatology and Syphilology [14]	5 days duration, full time, May 23-27, 1949	100.00
DIABETES			
University of California, Medical Extension, San Francisco 22	Endocrinology, including Diabetes	5 days, full time, June 20-24, 1949	Not given
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Course in Medical and Surgical Diabetes	1 day each week for 10 weeks, March 16	60.00
Harvard Medical School, 25 Shattuck St., Boston 15 At: New England Deaconess Hospital	Diabetes in Relation to General Medicine	5 days, full time, Monday, July 11-15, 1949	Not given

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	DIABETES—Continued		
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Pratt Diagnostic Hospital	Diabetes	6 days, full time, March 28-April 2, 1949	40.00 [3] 5.00 [4]
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Maimonides Hospital	Diabetes Mellitus	12 weeks, part time, beginning April 1949	30.00
New York University College of Medicine, 477 First Ave., New York 16 At: New York Post-Graduate Medical School, 308 E. 20th St., New York 3	B-327, Diabetes Mellitus, Nephritis and Hypertension	5 days, full time, March 14-18, 1949	85.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16 At: Lenox Hill Hospital	A-384, Diabetes Mellitus	6 weeks, part time, Monday and Thursday, 5-6:30 p.m., Jan. 10-Feb. 17, 1949; April 4-May 12, 1949	30.00
The Frank E. Bunts Educational Institute, 2089 E. Ninety-Third St., Cleveland At: The Cleveland Clinic Foundation	Diabetes	2½ days, Thursday, Friday and Saturday, March 17-19, 1949	15.00
University of Oregon Medical School, Marquam Hill, Portland 1, Oregon	Diabetes	3 days, Jan. 31-Feb. 2, 1949	30.00
	ELECTROCARDIOGRAPHY		
University Extension in cooperation with University of California Medical Schools, San Francisco and Los Angeles At: University of California at Los Angeles Campus	Electrocardiography	6 meetings of 2 hours, January 4-20, Tuesdays and Thursdays	15.00
University of California Medical School, University Extension, San Francisco 22	Interpretation of Electrocardiograms	5 days, part time, Jan. 31-Feb. 3, 1949, to be announced	To be announced
Michael Reese Hospital Postgraduate School, 29th and Ellis Ave., Chicago 16	Electrocardiographic Interpretation	13 weeks, 2 hours per week, Feb. 9-May 3, 1949	50.00
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Pratt Diagnostic Hospital, Boston	Electrocardiography I	5 days, full time, Feb. 28-March 4, 1949	40.00 [3] 5.00 [4]
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Beth El Hospital At: Jewish Hospital At: Maimonides Hospital	Basic Electrocardiography	5 weeks, part time, beginning April 1949	30.00
	Clinical Electrocardiography	5 weeks, part time, beginning April 1949	30.00
	Electrocardiography and Clinical Cardiology	5 weeks, part time, beginning April 1949	30.00
	Clinical Cardiology and Advanced Electrocardiography	4 weeks, part time, beginning April 1949	30.00
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Intensive Course in Elementary Electrocardiography (Medicine PM-41)	5 days, full time, Jan. 17-22, 1949	60.00
	Intensive Course in Advanced Electrocardiography (Medicine PM-42)	5 days, full time, March 29-April 2, 1949	60.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 E. 106th St., New York City	Electrocardiography	2 weeks, full time, April 1949	100.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Electrocardiographic Interpretation	2 weeks, part time, 2 hours daily, arranged	75.00
New York University-Bellevue Medical Center, Post-Graduate Medical School, 477 First Ave., New York 16 At: Beth Israel Hospital	A-372, Electrocardiography	12 weeks, part time, Thursdays 2-5 p.m., Jan 6-March 24, March 31-June 16, 1949	60.00
	A-373, Practical Electrocardiography for the Practicing Physician	6 weeks, part time, Tuesday 1-4 p.m., Jan. 4-Feb. 8, April 5-May 10, 1949	65.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-345, Electrocardiography	5 days duration, full time, Feb. 28, March 4, 1949	85.00
	A-380, Fundamentals of Electrocardiographic Theory	16 weeks, part time, Thursdays 9-11 a.m., March 3-June 16, 1949	125.00
University of Oregon Medical School, Marquam Hill, Portland 1, Oregon	Electrocardiography	5 days, June 13-17, 1949	50.00
The American College of Physicians, 4200 Pine St., Philadelphia 4 At: Massachusetts General Hospital, Boston	Electrocardiography	1 week, full time, April 25-30, 1949	60.00 [4] 120.00 [5]
	ELECTROENCEPHALOGRAPHY		
University of Colorado Medical Center, 4200 E. Ninth Ave., Denver 7 At: Electroencephalography Laboratory of Colorado Psychopathic Hospital and Associated Laboratories	Electroencephalography [17]	12 weeks, first Monday in March 1949	125.00
University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12 At: Univ. of Illinois—Illinois Neuropsychiatric Institute	Training Course in Electroencephalography	3 months, Winter and Spring quarters	200.00
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4 At: Graduate Hospital and Pennsylvania Institute	Electroencephalography	6 consecutive Thursdays, 36 hours 2 weeks, 36 hours Additional week Start first Thursday of October, January, March and May	150.00 200.00 100.00
	ENDOCRINOLOGY		
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	Endocrinology	8 periods, 12 hours, begins April 4, 1949	30.00
University of California Medical School, University Extension, San Francisco 22	Endocrinology, including Diabetes	5 days, full time, June 20-24, 1949, to be announced	To be announced
University of Georgia School of Medicine, University Place, Augusta, Ga.	Endocrinology	May or June (tentative)	Not given
University of Michigan Medical School, Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich. At: University Hospital, Ann Arbor, Mich.	Metabolism and Endocrinology	5 days, March 21-25, 1949	30.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine At: Beth El Hospital At: Greenpoint Hospital At: Jewish Hospital At: Jewish Sanitarium and Hospitals for Chronic Diseases	Pediatric Endocrinology	8 weeks, part time, beginning April 1949	30.00
	Sterility [18]	12 weeks, part time, beginning April 1949	60.00
	Disorders of the Endocrine System	6 weeks, part time, beginning April 1949	60.00
	Female Sex Endocrinology	10 weeks, part time, beginning April 1949	30.00
	Applied Endocrinology	6 weeks, part time, beginning April 1949	30.00
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Endocrinological Diseases (Medicine PM 39)	2 months, part time, Jan. 24-March 21, 1949	30.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 E. 106th St., New York City	Endocrinology	3 weeks, full time, May 1949	150.00
	Physiology of the Endocrine System	1 month, to be arranged	75.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
ENDOCRINOLOGY—Continued			
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	A-322, Gynecological Endocrinology	Part time, Tuesdays, Thursdays, Saturdays 10 a.m. to 12 p.m., Jan. 4-Feb. 26, March 8-April 30, May 3-June 25, 1949	150.00
	A-309, Endocrinology	Part time, Fridays, 9 to 12 m., Jan. 7-Feb. 25, 1949	45.00
The Association for the Study of Internal Secretions, 1200 N. Walker St., Oklahoma City 3 At: Skirvin Hotel, Oklahoma City	Clinical Endocrinology	6 days, Feb. 21-26, 1949	100.00
The American College of Physicians, 4200 Pine St., Philadelphia 4 At: Tufts College Medical School, Boston	Endocrinology	1 week, full time, June 13-18, 1949	20.00 [1] 60.00 [2]
University of California Medical Extension, San Francisco	Endocrinology, including Diabetes	5 days, full time, June 20-24, 1949	Not given
ENDOSCOPY			
Georgetown University Medical Center, 3900 Reservoir Rd., N.W., Washington 7, D. C.	Intensive Graduate Course	2 weeks, April 18, 1949	Not given
University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12	Bronchoesophagology	Feb. 7-19, 1949	150.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	A-211, Cystoscopy and Endoscopy	Part time, Mon., Wed., Fri., 10 a.m.-12 m., Jan. 3-Feb. 4, Feb. 14-March 18, April 4-May 9, May 16-June 20, 1949	100.00
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4 At: University of Pennsylvania Surgical and Anatomical Laboratories, Graduate Hospital	Bronchoesophagology, Gastroscopy and Laryngeal Surgery	2 weeks, 85 hours, June	250.00
FRACTURES			
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Special Course in Fractures	1 day each week for 10 weeks, March 9	125.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Kings County Hospital	Fractures	10 weeks, part time, beginning April 1949	20.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 E. 106th St., New York City	Fractures and Allied Trauma	3 weeks, full time, Spring semester (1949)	150.00
GASTROENTEROLOGY			
American College of Physicians, 4200 Pine St., Philadelphia 4 At: University of California Medical School	Gastroenterology	5 days, full time, Feb. 7-11, 1949	To be announced
George Washington University School of Medicine, 1335 H St., N.W., Washington, D. C.	Gastroenterology	1 week, full time, May 9-13, 1949	50.00
	Gastrointestinal Problems in Pediatrics	1 week, full time, Feb. 7-11, 1949	50.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Two week Course in Gastroenterology	2 weeks, June 27	100.00
	Two week Personal Course in Gastroscopy and Gastroenterology	2 weeks, full time, March 7, May 16, June 13, July 18	200.00
	Part time Personal Course in Gastroenterology	1 day each week for 10 weeks, April 13	100.00
University of Michigan Medical School, Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich. At: University Hospital, Ann Arbor	Diseases of the Gastrointestinal Tract	5 days, March 14-18, 1949	30.00
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26 At: Receiving Hospital	Gastroenterology	1 hour/week, March 21-June 18, 1949	15.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Ath El Hospital At: Greenpoint Hospital At: Jewish Hospital At: Jewish Sanitarium and Hospital for Chronic Diseases	Gastroenterology (II)	5 weeks, part time, beginning April 1949	20.00
	Gastroenterology (III)	6 weeks, part time, beginning April 1949	20.00
	Gastroenterology (I)	5 weeks, part time, beginning April 1949	20.00
	Gastroenterology (IV)	12 weeks, part time, beginning April 1949	20.00
Columbia University, 630 W. 168th St., New York 32 At: Columbia-Presbyterian Medical Center At: Mount Sinai Hospital	Medicine PM-2, Gastroscopy [10]	2 months, hours to be arranged, 3 afternoons weekly	250.00
	Medicine PM-45, Intensive Course in Gastroenterology	5 days, full time, Jan. 10-14, 1949	50.00
	Gastrointestinal Diseases (Medicine PM-32)	2 months, Jan. 26-March 25, 1949	80.00
	Advanced Gastroscopy	5 weeks, two 2 hour periods each week, to be arranged	200.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 E. 106th St., New York City	Gastroenterology	1 month, full time, to be arranged	300.00
	Gastroscopy	2 weeks, part time, to be arranged	200.00
	Physiology and Chemistry of the Gastrointestinal Tract, Digestion	1 month, to be arranged	150.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Gastroenterology	6 weeks, 3 months, Jan. 3, April 4, Oct. 3, 1949	50.00 75.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16 At: Beth Israel Hospital At: Lenox Hill Hospital	A-375, Gastroenterology	8 weeks, part time, Mondays 3-5 p.m., Fridays 10-12 m., Jan. 10-March 4, April 4-May 27, 1949	45.00
	A-374, Gastroenterology	7 weeks, Mondays, Fridays, 10 a.m.-12 m. Jan. 3-Feb. 18, April 4-May 20, 1949	60.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	A-311, Gastroenterology	Part time, Wednesdays, 2 p.m.-5 p.m., Jan. 5-Feb. 23, 1949	45.00
	B-343, Gastroenterology	5 days duration, full time, April 18-29, 1949	100.00
The American College of Physicians, 4200 Pine St., Philadelphia 4 At: University of California Medical School and Stanford University School of Medicine, San Francisco	Gastroenterology	1 week, full time, Feb. 7-12, 1949	30.00 [1] 60.00 [2]
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4	Clinical Gastroenterology	16 weeks (300 hours), February 1949	600.00
University of Wisconsin Medical School, 418 N. Randall St., Madison	Observation Course in Gastroenterology	5 days, full time, Feb. 14-18, 1949	25.00
GERIATRICS			
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Geriatrics (Medicine PM-47)	3½ months, part time, Feb. 3-May 19, 1949	65.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	HEMATOLOGY		
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Personal Course in Hematology	10 weeks, one day each, April 20	100.00
	Personal Course in Hematology	1 week, June 27	100.00
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Pratt Diagnostic Hospital	Hematology II	2 weeks, full time, May 16-28, 1949	100.00 [9] 5.00 [4]
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Hematology Case Study	1 hour/week, March 21-June 18, 1949	50.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Jewish Hospital	Clinical Hematology	8 weeks, part time, beginning April 1949	20.00
Columbia University, 630 W. 168th St., New York 16 At: Mount Sinai Hospital	Medicine PM-35, Hematology	2 months, once a week, 3 hours, Jan. 24-March 21, 1949	60.00
New York Medical College, Flower and Fifth Avenue Hospitals, 30 E. 106th St., New York City	Hematology	2 months, Tuesday afternoons, to be arranged	50.00
New York University-Bellevue Medical Center, Post-Graduate Medical School, 477 First Ave., New York 19 At: Lenox Hill Hospital	A-377, Hematology	6 weeks, part time, Wednesdays 1-3 p.m. Jan. 5-Feb. 9, April 6-May 11, 1949	50.00
New York University-Bellevue Medical Center, Post-Graduate Medical School, 477 First Ave., New York 19	A-308, Clinical Hematology	Part time, Wednesdays 2-4 p.m., Jan. 5-Feb. 23, 1949	30.00
American College of Physicians, 4200 Pine St., Philadelphia 4 At: Ohio State University College of Medicine, Columbus	The Hematologic Emphasis in Clinical Medicine	1 week, full time, Feb. 14-19, 1949	30.00 [1] 60.00 [9]
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4 At: Bryn Mawr Hospital Laboratories	Clinical and Laboratory Hematology	6 weeks, start first of February and April 1949	200.00
Baylor University College of Medicine, Department of Medicine, 509 Lincoln Ave., Houston 1, Texas	Hematology	4 days, January 3-6	50.00
	HISTOLOGY		
New York Medical College, Flower and Fifth Avenue Hospitals, 30 E. 106th St., New York City	Histology	5 weeks, full time, to be arranged	200.00
	HOSPITAL ADMINISTRATION		
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York	Seminar in Hospital Administration [40]	Arranged	Not given
	INDUSTRIAL HEALTH		
Wayne University School of Occupational Health, Detroit	Continuation Study [41]	Every week, first six months of 1949	Not given
	INTERNAL MEDICINE		
University of California, The School of Medicine and University Extension, 400 Hilgard Ave., Los Angeles 24 At: Quonset Hut Conference Room, General Medical and Surgical Hospital, V. A. Center, Los Angeles	Dermatology in Internal Medicine	8 weeks, part time, Jan. 3-Feb. 21, 1949	35.00
The George Washington University School of Medicine and Hospital, 1325 H St., N.W., Washington 5, D. C.	Internal Medicine	5 weeks, full time, April 11-May 13, 1949	250.00
Emory University School of Medicine, 104 Physiology Bldg., Emory University, Ga. At: Grady Memorial Hospital, Emory University Hospital	General Internal Medicine	2 weeks to 1 year, arranged	12.00 [14] 125.00 [9]
Michael Reese Hospital Postgraduate School, 29th and Ellis Ave., Chicago 16	Recent Advances in Internal Medicine	10 days, full time, May 23-June 3, 1949	100.00
Tulane University School of Medicine, 1430 Tulane Ave., New Orleans 12	Review Internal Medicine	2 weeks, Jan. 24-Feb. 5, 1949	60.00
Harvard Medical School, 25 Shattuck St., Boston 15 At: Boston City Hospital, Boston At: Massachusetts General Hospital, Boston	Internal Medicine 2	3 months, daily, all day, beginning June 1, 1949	375.00
	Internal Medicine 3	39 days, daily, all day except Saturdays, June 20-July 29, 1949	250.00
Tufts College Medical School, Postgraduate Division, 30 Bennet St., Boston 11 At: Pratt Diagnostic Hospital	Internal Medicine as Routed to Basic Sciences	9 weeks, full time, Jan. 3-Feb. 26, 1949	200.00 [9] 5.00 [4]
University of Michigan Medical School, Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich. At: University Hospital, Ann Arbor	Clinical Internal Medicine	26 days, Jan. 6-April 21, 1949, Thursdays (p.m.)	50.00
	Diseases of the Blood and Blood-Forming Organs	5 days, April 11-15, 1949	30.00
Mississippi State Sanatorium, Sanatorium, Miss.	Internal Medicine and Diseases of the Chest	1 week to 6 months, year round	None
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinal Hospital	Diseases of the Liver (Medicine PM-33)	2 months, part time, Jan. 25-March 24, 1949	25.00
	Diseases of the Kidneys (Medicine PM-34)	2 months, part time, Jan. 24-March 21, 1949	15.00
	Diseases of Metabolism (Medicine PM-28)	2 months, part time, Jan. 27-March 25, 1949	40.00
	Symposium on Internal Medicine (Medicine PM-30)	2 months, full time, Jan. 24-March 28, 1949	250.00
Cornell University Medical College, 1300 York Ave., New York 12 At: Bellevue Hospital	Graduate Instruction in Internal Medicine	6 months, full time, admitted first of each month	300.00
New York Medical College, Flower and Fifth Avenue Hospitals, 30 E. 106th St., New York City	Internal Medicine	1 month, full time	150.00
		2 months, full time, except July and August	300.00
New York University-Bellevue Medical Center, Post-Graduate Medical School, 477 First Ave., New York 16	A-315, Psychological Aspects of Internal Medicine	Part time, Fridays, 3:30 p.m. to 5 p.m., Jan. 7-Feb. 25, 1949	25.00
	B-330, Seminar in Internal Medicine	8 weeks, full time, Jan. 3-Feb. 25, 1949	300.00
	B-341, Symposium on Internal Medicine	10 days, full time	100.00
	A-381, Internal Medicine	5 days, full time, June 13-24, 1949	55.00
		4 weeks, Jan. 3-28, 1949	60.00
		9 weeks, Jan. 3-Feb. 25, 1949	100.00
		12 weeks, Jan. 3-March 25, 1949	150.00
		4 weeks, April 4-29, 1949	60.00
		6 weeks, April 4-May 27, 1949	100.00
		12 weeks, April 4-June 24, 1949	150.00
		20 weeks, January to June, 1 day a week	60.00 [13]
At: Beth Israel Hospital	A-378, Internal Medicine	5 weeks, part time, Wednesdays and Fridays 2-5 p.m., April 6-May 27, 1949	75.00
New York Post-Graduate Medical School, 303 E. 20th St., New York 3	B-340, Peripheral Vascular Diseases	5 days, full time, March 21-25, 1949	55.00
University of Cincinnati College of Medicine, Eden & Bethesda Aves., Cincinnati, and Society of General Physicians, Cincinnati At: Univ. of Cincinnati College of Medicine, Cincinnati	Medicine, Gynecology and Urology	1 month, twice a week, 2 hours, Feb. 15, 1949 and March 1949	Not given

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
INTERNAL MEDICINE—Continued			
Oklahoma State Health Dept., Oklahoma State Medical Association, 3400 North Eastern, Oklahoma City 5, and 210 Plaza Court Bldg., Oklahoma City 3 At: 40 cities and towns over the state	Internal Medicine	10 weeks (1 lecture a week for 10 weeks in each teaching center), two-year program for 1949-1950	20.00
The American College of Physicians, 4200 Pine St., Philadelphia 4 At: Massachusetts General Hospital, Boston At: University of Pennsylvania Graduate School of Medicine, Philadelphia	Internal Medicine [19] Physiological Basis for Internal Medicine [25]	2 weeks, full time, March 7-19, 1949 1 week, full time, May 9-14, 1949	60.00 [1] 120.00 [2] 30.00 [1] 60.00 [2]
Washington State Medical Association, University of Washington Medical School, Seattle At: Harborview Hospital	Postgraduate Course in Internal Medicine	5 days, Jan. 10-14, 1949	25.00
MALIGNANT DISEASES			
Local County Medical Society, 1925 Wilshire Blvd., Los Angeles 5; Cancer Commission, California Medical Association, 450 Sutter St., San Francisco 8; California Division, American Cancer Society (State Department of Public Health), San Francisco At: In non-metropolitan areas of the state	Cancer Symposium	Either one or two days as selected by the local medical society	None
University of California Medical School, San Francisco 22	Symposium on Tumors	June 27 to June 29, 1949	Not given
American Cancer Society, University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12	Postgraduate Course in Cancer	One day at the U. of Illinois, four other days at other institution in Chicago, three times per year	None
Yale University School of Medicine, 333 Cedar St., New Haven 11, and Connecticut State Medical Society, 256 Church St., New Haven 10 At: Yale University School of Medicine	Surgery 208, Early Diagnosis of Cancer	12 sessions, 2 hours each, March 25-June 10, 1949	45.00
Indiana University School of Medicine, 1040 W. Michigan St., Indianapolis 7, and Indiana Cancer Society, Indianapolis At: Indiana University School of Medicine, Indianapolis	Second Annual Post-Graduate Course in Malignancy	2 days, full time, April 6 and 7, 1949	None
Michigan State Medical Society Cancer Committee, 2020 Olds Tower, Lansing 8, and University of Michigan Medical School, Department of Postgraduate Medicine, 109 S. Observatory St., Ann Arbor, Mich. At: University Hospital, Ann Arbor	Cancer	4 days, Jan. 25-28, 1949	25.00
University of Minnesota Center for Continuation Study, Minneapolis 14	Cancer Control Cancer Control	3 days, March 2-5, 1949 3 days, June 2-4, 1949	To be announced To be announced
Cornell University Medical College, 1300 York Ave., New York 12	Course in Cytologic Diagnosis of Cancer	Not given, limited to 25	100.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-930, The Basic Problems in Cancer Therapy, for Surgeons [18]	12 days, full time, Jan. 31-Feb. 12, 1949	200.00
Tennessee State Medical Association, 706 Church St., 508 Doctors Bldg., Nashville 3, Tenn. At: Forty-five County Seats and Teaching Centers	Cancer	10 weeks, 2 hours per week, January-September 1949	10.00 2.50 [13]
University of Texas School of Medicine, Postgraduate Division, Galveston, Texas	Tumor Course Tumor Conference	3½ days, Feb. 2-5, 1949 4 days, April 4-9, 1949	20.00 20.00
University of Utah, Second, South and University Sts., Salt Lake City 1	Symposium on Cancer	Spring Quarter (tentative)	Not given
Medical Society of Milwaukee County and American Cancer Society, 208 E. Wisconsin Ave., 733 Bankers Bldg., Milwaukee 2	Third Annual Milwaukee Cancer Symposium	2 days, April 7, 8, 1949	None
MEDICINE, GENERAL			
The Medical College of Alabama, 620 S. 20th St., Birmingham 5, Ala.	General Review for General Practitioner	3 days, Spring 1949, exact date not set	None
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles	Differential Diagnosis and Treatment of Internal Diseases Varicose Veins	12 periods, 18 hours, beginning Jan. 3, 1949, Mondays 4-9:30 p.m. 6 periods, 12 hours, begins March 3, 1949, Thursdays 7-9 p.m.	50.00 25.00
Los Angeles County Medical Association, 1925 Wilshire Blvd., Los Angeles 5	Practical Medicine Series Practical Medicine Series	1½ hours per week, continuously, every Tuesday 1½ hours per week, continuously, every Wednesday	None None
Research Study Club of Los Angeles, Inc., 727 W. 7th St., Los Angeles At: Elks Club, Los Angeles	Eighteenth Annual Mid-Winter Post-Graduate Clinical Convention	2 weeks, Clinical, Jan. 17-28, 1949 Cadaver, Jan. 29-Feb. 1, 1949	75.00 75.00
University Extension in cooperation with University of Calif. Med. Schools, San Francisco and Los Angeles At: 217 W. First St., Los Angeles	Infectious Diseases	13 meetings of 2 hours, Jan. 6 weekly to March 31, 1949	None
Colorado State Medical Society, 835 Republic Bldg., Denver 2	Fourteenth Annual Midwinter Postgraduate Clinics	3 days, March 2, 3 and 4, 1949	Registration Fee
Yale University School of Medicine and Connecticut State Medical Society, 333 Cedar St., New Haven 11, and 256 Church St., New Haven 10 At: Community Hospitals	Medicine 202, Metabolism	8 sessions, decided by hospitals	300.00
The George Washington University Medical School and Hospital, 1335 H St., N.W., Washington 5, D. C.	General Medicine Neoplastic Diseases Metabolic Diseases Ocular Pathology, Motility and Orthoptics Course for General Practitioners	3 weeks, full time, Jan 31-Feb. 18, 1949 1 week, full time, April 4-8, 1949 1 week, full time, April 11-15, 1949 1 week, full time, Jan. 10-14, 1949 1 week, March or April	150.00 50.00 50.00 150.00 Not given
Medical Association of Georgia, 478 Peachtree St., N.E., Atlanta 3, Ga. At: University of Georgia School of Medicine, University Place, Augusta, Ga.			
University of Georgia School of Medicine, University Place, Augusta, Ga.	Annual Course for Negro Physicians	Not given, later half of June 1949	Not given
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	One month Personal Course in Asthma, Hay Fever and Allied Diseases Six month Personal Course in Asthma, Hay Fever and Allied Diseases Two week Intensive Course in General Medicine	1 month, first of every month 6 months, by appointment 2 weeks, full time, April 4, June 18	200.00 500.00 75.00
Chicago Medical Society, 30 N. Michigan Ave., Chicago 2	Clinical Conference	4 full days, March 1-4, 1949	5.00 [13]
Educational Committee, Illinois State Medical Society, 224 S. Main St., Monmouth At: LaSalle, Springfield, Quincy and Duquoin, Illinois	Postgraduate Conferences	1 day in length, LaSalle, Spring 1949; Springfield, March 8, 1949; Quincy, Spring 1949; DuQuoin, Spring 1949	None
Vanderburgh County Medical Society; Indiana School of Medicine; Evansville College; Indiana State Medical Association, 332 Third and Main Bldg., Evansville 8, Ind.; 1040 W. Michigan St., Indianapolis 7; Evansville, Ind., and 32 E. Ohio St., Indianapolis 4 At: Evansville College, Evansville, Ind.	Graduate Education Program of the Vanderburgh County Medical Society	9 months, one day a month, Jan. 1, 1949	None [20]

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution At: Yale University School of Medicine	Title of Course	Schedule of Course	Registration Fee and/or Tuition
MEDICINE, GENERAL—Continued			
St. Elizabeth Hospital and Indiana University School of Medicine, 1040 W. Michigan St., Indianapolis 7 At: Lafayette, Ind.	Postgraduate Medical Education	1 day a month, 2 hours a day, first Tuesday of each month	None
State University of Iowa College of Medicine, University Campus, Iowa City	General Surgery	4 days, probably late April	25.00
University of Louisville School of Medicine, 101 W. Chestnut St., Louisville 2, Ky., and Kentucky State Medical Association, 620 S. Third St., Louisville 2, Ky. At: Louisville General Hospital	Intensive Refresher Course in Medicine and Surgery	5 days, June 1949 (exact dates not scheduled as yet)	25.00
Louisiana State University and Tangipahoa Parish Medical Society, 1542 Tulane Ave., New Orleans 13 At: Independence Charity Hospital, Independence, La.	Continuation Course for General Practitioners	22 hours, part time, 1 session every two weeks, Jan. 1-March 22, 1949	None
Flint-Goodridge Hospital of Dillard University, New Orleans	Postgraduate Course for Practicing Physicians	1 week, not given	5.00
Post-Graduate Committee, University of Maryland School of Medicine and County Medical Societies, Lombard and Greene Sts., Baltimore 1 At: University Hospital and County Hospitals in Maryland	Postgraduate Extension Lecture Series	Once a month, 3:30-9:00 p.m., January-May 1949	15.00
Lahey Clinic, 605 Commonwealth Ave., Boston 15	General Clinical Subjects	Wednesdays 7:30-9:30 p.m., throughout year except July and August	None
Lahey Clinic, 605 Commonwealth Ave., Boston 15 At: New England Deaconess and New England Baptist Hospitals	Medical Clinics	Tuesdays and Thursdays 4:45 p.m., Saturdays 11 a.m., throughout year except July and August	None
Michigan State Medical Society, 2920 Olds Tower, Lansing 8, Mich.; University of Michigan Medical School, 1313 E. Ann St., Ann Arbor, Mich.; Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26; Michigan Department of Health, Lansing 4, Mich. At: Various cities	Extramural Course	2 days in Spring of each year, dates for Spring 1949 to be arranged later	No fee
At: Book Cadillac Hotel, Detroit	Extramural Course	2 days in Autumn, 2 days in Spring, Spring 1949 dates not yet determined	None
	Michigan Postgraduate Clinical Institute	3 days, March 23, 24, 25, 1949	None
University of Michigan Medical School Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich.	Summer Session Courses in Anatomy, Bacteriology and Biological Chemistry	6 and 8 weeks, June 20-Aug. 13, 1949	50.00 *
University of Michigan Medical School Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich. At: University Hospital, Ann Arbor	Rheumatology and Recent Advances in Therapeutics	5 days, March 28-April 1, 1949	30.00
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26 At: Wayne County General Hospital	Diagnostic Conference	1 hour/week, March 21-June 18, 1949	15.00
At: Receiving Hospital At: Wayne County General Hospital	Diagnostic Conference Medical Pathological Conference	2 hours/week, March 21-June 18, 1949 1 hour/week, March 21-June 18, 1949	15.00 15.00
University of Minnesota Center for Continuation Study, Minneapolis 14	General Medicine	3 days, May 12-14, 1949	To be announced
Missouri State Medical Association, 634 N. Grand Blvd., St. Louis 3 At: Kansas City, Mo.	Scientific Program on General Practice (Includes Heart Disease, Trauma, Obstetrics and selected subjects)	2½ days, March 27-30, 1949	No fee
Washington University School of Medicine, Euclid Ave. and Kingshighway, St. Louis 10	Review Course for General Practitioners	2 weeks, May 1949	Not given
University of Nebraska College of Medicine, 42d St. and Dewey Ave., Omaha 5	Refresher Course for Practicing Physicians Refresher Courses (Medicine, Surgery and Their Allied Specialties) Postgraduate Medicine	4 days, May 1949 1 week, first six months of 1949 6 weeks, beginning February 1949	25.00 25.00 Not given
Rutgers University, Extension Division, Newark Center, 23 Washington St., Newark 2, N. J. At: Cumberland County Medical Society, Bridgeton, N. J. At: Hudson County Medical Society, Jersey City, N. J.	Short Postgraduate Courses in Medicine	6 weeks, beginning April 1949	Not given
At: Morris County Medical Society, Morristown, N. J.	Short Postgraduate Courses in Medicine	6 weeks, beginning April 1949	Not given
At: Mercer County Medical Society, Trenton, N. J.	Short Postgraduate Courses in Medicine	6 weeks, beginning May 1949	Not given
Joint Committee on Post-Graduate Educational Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Brooklyn Cancer Institute, Kings County At: Long Island College of Medicine	Diagnosis and Treatment of Neoplastic Disease	8 weeks, part time, beginning April 1949	30.00
	Manikin	8 weeks, part time, beginning April 1949	30.00
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Medicine PM-34, Diseases of the Kidneys Medicine PM-33, Diseases of the Liver Medicine PM-38, Diseases of Metabolism Friday Afternoon Lectures Immunology	3 months, once a week, one hour, Jan. 24-March 21, 1949 2 months, twice a week, one hour, Jan. 24-March 24, 1949 2 months, once a week, two hours, Jan. 27-March 25, 1949 Jan. 7-March 18, 1949 6 weeks, half time, to be arranged	15.00 25.00 40.00 Not given 50.00
New York Academy of Medicine, 2 E. 103rd St., New York 29 New York Medical College, Flower and Fifth Avenue Hospitals, 50 E. 106th St., New York City New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	General Practitioner's Course	6 weeks, full time, April 4, Oct. 3, 1949	100.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-327, Diabetes Mellitus, Nephritis and Hypertension B-329, Diagnosis and Treatment of Trauma A-1421, Differential Diagnosis with the Slit Lamp [16] A-310, Diseases of the Liver and Biliary Tract A-313, Nephritis and Hypertension Postgraduate Courses in Forensic Medicine Course C-A, Short Course in Legal Medicine Course D, Intensive Laboratory Course in Medicolegal Necropsy Course E, Intensive Course in Forensic Medicine Course F, Toxicology Course G, Research in Toxicology Course H, Lectures on Medical Criminology and Police Science	5 days duration, full time, March 14-18, 1949 6 days duration, full time, May 9-14, 1949 5 days duration, part time, 9 a.m. to 1 p.m., Feb. 28-March 4 Part time, Wednesdays, 11 a.m.-1 p.m., Jan. 5-Feb. 23, 1949 Part time, Thursdays 2 p.m. to 4 p.m., Jan. 6-Feb. 24, 1949 Part time, by arrangement 1 month duration, daily except Saturday, 10-11 a.m. Arranged, daily except Saturday, 10-12 p.m. 1 month, daily except Saturday, 2-4 p.m., January-April Arranged Arranged 1 week duration, Mon. through Fri., 10-12 p.m., 2-5:30 p.m., dates arranged	35.00 60.00 75.00 30.00 30.00 75.00 75.00 * 75.00 Arranged Arranged 25.00

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Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
MEDICINE, GENERAL—Continued			
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Course B, Necropsy and Laboratory Demonstrations	Saturday 10-12 p.m., last Saturday in January to second Saturday in May 1949, minimum period one month	Arranged
	A-307, Problems in Diagnosis	Part time, Mondays, 9 a.m. to 12 m., Jan. 3-Feb. 21, 1949	45.00
St. Mary's Hospital and Council of Rochester Regional Hospitals, 809 Reynolds Arcade Bldg., Rochester 4, N. Y.	Diagnosis and Treatment in General Practice	5 days, full time, March 14-18, 1949	None [14]
	Diagnosis and Treatment in General Practice	5 days, full time, April 25-29, 1949	None [14]
University of North Carolina School of Medicine and Extension Division, Chapel Hill, N. C. At: Salisbury, Goldsboro, Wilmington	Medical Postgraduate Extension Course	6 to 8 weeks, one day a week, exact dates not determined, February to May probably	20.00 to 30.00
University of Cincinnati College of Medicine and Society of General Physicians At: University of Cincinnati College of Medicine	Mechanisms of Disease	8 sessions, Tuesday and Thursday a.m. through January 1949	15.00
	Medicine, Gynecology and Urology	1 month, twice a week, Feb. 15, 1949 (tentative)	Not given
	Medicine, Gynecology and Urology	1 month, twice a week, March 1949 (tentative)	Not given
	Laboratory Diagnosis and Practice	1 month, twice a week, May 15, 1949 (tentative)	Not given
	Laboratory Diagnosis and Practice	1 month, twice a week, June 1949 (tentative)	Not given
Medical Society of the State of Pennsylvania, 309 Penn Ave., Pittsburgh At: Various towns	Graduate Education Institute of The Medical Society of the State of Pennsylvania	1 day per week for 5 weeks, Spring 1949	25.00 [19]
Tennessee Valley Post-Graduate Medical Assembly, 409 Doctors' Bldg., Knoxville	Postgraduate	Spring 1949 (date not yet set)	5.00
Dallas Southern Clinical Society, Dallas, Texas	Clinical Conference	4 days, full time, March 14-17, 1949	20.00
Prairie View University, Lone Star Medical Association and Texas Tuberculosis Association At: Prairie View University, Prairie View, Texas	Prairie View Postgraduate Medical Assembly	4 days, full time, March 1-4, 1949	None
International Postgraduate Medical Assembly of Southwest Texas, San Antonio	Postgraduate Course	3 days, full time, Jan. 25-27, 1949	15.00
University of Wisconsin Medical School, 415 N. Randall St., Madison	Observation Course in Medicine [15]	2-6 months, arranged	100.00 [6]
NEUROLOGY AND PSYCHIATRY			
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 23	Neurology	8 periods, 12 hours, beginning Jan. 6, 1949	30.00
University of California Medical School, University Extension, San Francisco At: University of California Medical School	Psychiatry for General Practitioners	5 days, full time, Jan. 31-Feb. 4, 1949	To be announced
Yale University School of Medicine, 333 Cedar St., New Haven 11, Conn. ...: Affiliated Hospitals	Psychiatry 200, Second Connecticut Seminar of Neurology, Psychiatry and Related Fields of Medicine	123 lectures, Jan. 3-April 29, 1949 [16]	75.00
At: Southbury Training School, Southbury, Conn.	Pediatrics 201, Pediatric Neurology	8 lectures, April 8-29, 1949	15.00
At: Yale University School of Medicine	Psychiatry 201, Fundamentals of Analytic Psychology and Psychopathology	Every 2 weeks, evenings, Jan. 14-March 25, 1949	25.00
United States Public Health Service, Washington, D. C.	Courses in Mental Health	Not given	Not given
Catholic University, Department of Psychology and Psychiatry, Washington, D. C. At: St. Elizabeth's Hospital At: Catholic University	Clinical Psychiatry	15 weeks, 2 hours weekly, Feb. 1-May 30, 1949	25.00
	Introductory Rorschach Analysis	15 weeks, 2 hours weekly, Feb. 1-May 30, 1949	25.00
At: Child Center, Catholic University	Psychosomatic Medicine	15 weeks, 2 hours weekly, Feb. 1-May 30, 1949	25.00
	Psychotherapy II	15 weeks, 2 hours weekly, Feb. 1-May 30, 1949	25.00
	Psychotherapy III	15 weeks, 2 hours weekly, Feb. 1-May 30, 1949	25.00
George Washington University Medical School, 1335 H St., Washington 5, D. C.	Psychosurgery	5 days, full time, Jan. 24-28, 1949	50.00
	Psychiatry	2 weeks, full time, Jan. 31-Feb. 11, 1949	100.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago	Part time Personal Course in Clinical Neurology	10 weeks, 1 day each week, April 20, 1949	60.00
Institute for Psychoanalysis, 664 N. Michigan Ave., Chicago At: Illinois Neuropsychiatric Institute	Psychosomatic Demonstrations	January-June 1949, Tuesday afternoons	None
Michael Reese Hospital, Institute for Psychoanalysis, 29th and Ellis Ave., Chicago At: Michael Reese Hospital	Psychopathological Demonstrations	January-June 1949, Monday afternoons	None
Michael Reese Hospital Postgraduate School, Chicago	Rorschach Course [17]	1 week, part time, June 6-10, 1949	40.00
	Continuous Case Seminar (Group Control)	92 hours, weekly	Arranged
	Interpretation of Dreams, Parts I and II	18 hours, weekly	Arranged
Topeka Institute for Psychoanalysis, 3617 W. Sixth Ave., Topeka, Kan. At: Menninger Clinic	Psychoanalytic Literature	46 hours, bi-weekly	Arranged
	Psychoanalytic Contributions to the Theory and Treatment of Psychoses	15 hours, weekly	Arranged
	Psychoanalytic Technique, Part II	18 hours, weekly	Arranged
University of Maryland School of Medicine, Lombard and Greene Sts., Baltimore	Neuropathology (Laboratory Course)	6 months, full time, arranged	200.00 [18]
Commonwealth of Massachusetts, Department of Mental Health, Waltham At: Boston Psychopathic Hospital	Fourteenth Postgraduate Seminar in Neurology and Psychiatry, Course in Social and Special Psychiatry	36 lectures, every Wednesday, March 16-May 11, 1949	None
At: Metropolitan State Hospital, Waltham	Fourteenth Postgraduate Seminar in Neurology and Psychiatry, Review Course in Basic Neurology and Psychiatry	68 lectures, every Friday, March 4-May 20, 1949	None
At: Walter E. Fernald State School, Waltham	Postgraduate Seminar in Neurology and Psychiatry (Pediatric Neuropsychiatry)	20 hours, every other Monday, March 14-May 9, 1949	None
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Jewish Hospital	Child Psychiatry	10 weeks, part time, beginning April 1949	10.00
At: Jewish Sanitarium and Hospital for Chronic Diseases	Basis of Neural Function	8 weeks, part time, beginning April 1949	10.00
	Clinical Neurology	9 weeks, part time, beginning April 1949	10.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	and/or Tuition Registration Fee
	NEUROLOGY AND PSYCHIATRY—Continued		
American Institute for Psychoanalysis, 268 West End Ave., New York 23	Clinical Conferences [19]	10 sessions, weekly, beginning Feb. 14, 1949	30.00
	Readings in Psychoanalysis, Part III (The Works of Karen Horney)	12 weekly lectures, beginning April 4, 1949	24.00
	Sexual Problems in Neurosis	6 weekly lectures, beginning Feb. 9, 1949	12.00
	The Analytic Process [19]	15 weekly sessions, beginning Jan. 14, 1949	45.00
At: New School for Social Research, 66 W. 12th St., New York	Neuroses and Psychoses	15 weekly lectures, beginning Feb. 7, 1949	17.50
	Seminar on Personal Case Histories	15 weekly seminars, beginning Feb. 8, 1949	30.00
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York 32 At: Columbia-Presbyterian Medical Center	Neurology (PM-1), Advanced Neurology [19]	3 months, full time, Jan. 3-April 1, 1949	150.00
	Neurology (PM-1), Advanced Neurology [19]	3 months, full time, April 4-June 30, 1949	150.00
At: Mt. Sinai Hospital	Neurology (PM-1), Clinical Electroencephalography and Electromyography [19]	3 months, full time, January-March 1949	150.00
	Psychiatry in General Medicine (Psychiatry PM-30)	5 months, part time, Feb. 9-June 29, 1949	100.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Neurological and Psychiatric Diagnosis and Treatment in General Practice (B-713)	2 weeks, full time, May 9-21, 1949	100.00
	Neurology and Psychiatry for Pediatricians (B-720) [19]	2 weeks, full time, March 28-April 9, 1949	100.00
New York Psychoanalytic Institute, 245 E. 82nd St., New York 28	Rorschach Seminar # 10	10 sessions, every Thursday night, Jan. 6-March 10, 1949	20.00
	Psychological Problems in Medical Practice, # 32	10 sessions, every Friday night, March 18-May 27, 1949	20.00
William Alanson White Institute of Psychiatry, 12 E. 86th St., New York 28 At: 133 E. 74th St., New York	Seminar on Interpretation of Rorschach Records [22]	8 sessions, weekly, beginning Feb. 2, 1949	20.00
	Social Psychology	11 sessions, Jan. 11, 1949 and every other Tuesday thereafter	20.00
University of Rochester School of Medicine, Strong Memorial Hospital and Council of Rochester Regional Hospitals, Rochester, N. Y.	Psychiatry in General Practice	5 days, full time, dates to be announced	None [14]
University of Oklahoma School of Medicine and Oklahoma State Health Department, Oklahoma City, Okla.	Postgraduate Course in Psychiatry	3 days, May 9-11, 1949	Not given
Philadelphia Psychoanalytic Institute, 2031 Locust St., Philadelphia	Clinical Conferences on Problem Children [24]	5 sessions, Jan.-May 3, 1949	7.50
	Introduction to Child Psychiatry	28 sessions, Jan.-April 26, 1949	30.00
	Orientation Course in Normal Behavior [25]	10 sessions, Jan.-May 17, 1949	10.00
	Professional School Courses for Theory, Therapeutic Applications and Practice of Psychoanalysis [24]	Varies, Jan.-June 1949	$13.25 [23]
	Psychopathology of Childhood [24]	11 sessions, Jan.-May 31, 1949	11.00
	Psychoanalysis and Social Institutions [24]	4 sessions, March 31-May 12, 1949	9.00
	The Emotional Development of the Child [24]	9 sessions, Jan.-April 12, 1949	9.00
	NEUROSURGERY		
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York 32 At: Mt. Sinai Hospital	Clinical Neurology and Neurosurgery (Neurology PM-30)	5 days, full time, April 11-15, 1949	60.00
	NUTRITION		
Yale University School of Medicine and Connecticut State Medical Society, New Haven, Conn.	Medicine 288, Nutrition and Diet	11 sessions, March 17-June 11, 1949	40.00
New York Medical College, Flower and Fifth Avenue Hospitals, 50 E. 106th St., New York	Nutrition	1 month, arranged	150.00
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Nutrition and Metabolism	3 hours a week, March 21-June 18, 1949	35.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Diseases of Metabolism and Nutrition	12 weeks, part time, Jan. 3-March 21, 1949	60.00
	OBSTETRICS AND GYNECOLOGY		
University of California Medical School, University Extension, San Francisco 22	Obstetrics and Gynecology	4 days, full time, July 5-8, 1949	To be announced
The George Washington University School of Medicine and Hospital, 1335 H St., N.W., Washington 5, D. C.	Gynecology	1 week, full time, Feb. 21-25, 1949	50.00
	Obstetrics	1 week, full time, Feb. 14-18, 1949	50.00
Chicago Maternity Center, 1326 Newberry Ave., Chicago 8	Four-month Assistant Residency in Obstetrics (Chicago Mat. Center), Combined Four-Year Residency (between Chicago Maternity Center and Wesley Memorial Hospital)	4 months, 4 years, Assistant-Residency staggered, Residency every 6 months	None
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Two-week Intensive Course in Gynecology	2 weeks, full time, Feb. 21, March 21, April 18, June 20	150.00
	Personal Course on the Vaginal Approach to Pelvic Surgery	1 week, Feb. 14, April 4, May 16 and June 13	100.00
	Two-week Intensive Course in Obstetrics	2 weeks, March 7, April 4, May 16	150.00
	Part time Personal Course in Gynecological Surgery	4 weeks, one day each week, Jan. 13, Feb. 10, April 7, May 19, July 7	80.00
	Part time Practical and Didactic Course in Office Gynecology	4 weeks, one day each week, Jan. 12, Feb. 9, April 6, May 18, July 6	80.00
	Part time Personal Course in Office and General Obstetrics	4 weeks, one day each week, Jan. 5	80.00
	Part time Personal Course in Surgical Obstetrics	4 weeks, one day each week, Feb. 2	100.00
State Dept. of Public Health, State Medical Society, University of Illinois, 1853 W. Polk St., Chicago 12 At: Research and Educational Hospital	Review Course in Obstetrics and Gynecology	1 week, full time, second week in July	10.00
State University of Iowa College of Medicine, University Campus, Iowa City	Obstetrics and Gynecology	5 days, March 28-April 1, 1949	35.00
University of Louisville School of Medicine and Kentucky State Medical Association, 101 W. Chestnut St., Louisville 2, Ky., and 620 S. Third St., Louisville 2, Ky.	Intensive Refresher Course in Obstetrics and Gynecology	3 days, June 1949 (exact date not scheduled yet)	25.00
Tulane University School of Medicine, 1430 Tulane Ave., New Orleans 12	Review of Gynecology	5½ days, Jan. 17-22, 1949	30.00
	Review of Obstetrics	2 weeks, June 6-18, 1949	60.00
University of Maryland School of Medicine, Lombard and Greene Sts., Baltimore 1	Gynecology, Oncology and Female Urology	Not given, arranged	125.00
	Gynecology and Obstetrics "A"	12 weeks, 32 hours per week, arranged	150.00

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Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
OBSTETRICS AND GYNECOLOGY—Continued			
Harvard Medical School Courses for Graduates, 25 Shattuck St., Boston 15 At: Boston Lying-In Hospital	Clinical Obstetrics	1 month, full time, March 1949, April 1949, May 1949	150.00
University of Minnesota Center for Continuation Study, Minneapolis 14	Obstetrics	3 days, Jan. 6-8, 1949	To be announced
Columbia University Extension Division, 630 W. 168th St., New York 32 At: Margaret Hague Maternity Hospital	Obstetrics PM-80	3 months, first of every month	350.00 [20]
	Obstetrics PM-81, Observation Course	1 month, first of every month	100.00 [21]
At: Mount Sinai Hospital	Recent Advances in Gynecology (Gynecology PM-30)	5 days, April 4-9, 1949	65.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Cumberland Hospital	Complications of Pregnancy	4 weeks, part time, beginning April 1949	20.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Obstetrics and Gynecology including Manikin Obstetrics and Cadaver Gynecology	2 months, full time, April 4, 1949	250.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	A-303, Gynecology Diagnosis and Office Treatment	Part time, Mon., Wed., Fri., 2 p.m.-4 p.m., Jan. 3-Feb. 4, Feb. 14-March 18, April 4-May 6, May 16-June 20, 1949	75.00
At: Beth Israel Hospital	A-304, Gynecology	16 weeks, part time, Mon.-Fri., 8:30-12 m., Wed., 1:30-4 p.m., Jan. 17-May 6, 1949	250.00
	A-308, Gynecology for General Practitioners	12 weeks, part time, Mondays and Thursdays, 10-11:30 a.m., May 2-June 13, 1949	65.00
	A-225, Vaginal Cytology [19]	Part time, Tuesdays 12-1 p.m., Thursdays 9-12 m., Jan. 4-Feb. 25, March 8-April 29, May 3-June 24, 1949	100.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	A-241, Surgical Anatomy as Applied to Operative Gynecology	Part time, Tuesdays, Thursdays, Saturdays, 11 a.m.-12 m., Feb. 1-March 1, April 5-May 7, 1949	200.00
	B-308, Seminar in Gynecology	2 months, full time, Jan. 3-Feb. 26, March 7-April 30, May 2-June 25, 1949	300.00
	C-124, Gynecological Pathology [19]	16 weeks, part time, Tuesdays, Thursdays 2:30-4:30 p.m., Jan. 4-March 1, 1949	100.00
At: Lenox Hill Hospital	C-159, Histopathology for Gynecologists	5 weeks, part time, Tuesday and Friday, 8-9 p.m., March 1-April 1, 1949	50.00
University of Cincinnati College of Medicine and Society of General Physicians, Eden and Bethesda Aves., Cincinnati 29	Office Gynecology and Urology	8 sessions, 10-12 a.m., each Tues. and Thurs. morning thru month of May	15.00
Oklahoma City Obstetrical and Gynecological Society and The University of Oklahoma School of Medicine, 800 E. 13th St., Oklahoma City 4	Second Annual Review in Obstetrics and Gynecology	1 day, Jan. 15, 1949	Not given
University of Oklahoma School of Medicine, Oklahoma State Department of Health, 800 E. 13th St., Oklahoma City 4 At: University of Oklahoma School of Medicine	Postgraduate Course in Obstetrics	3 days, March 21-23, 1949	25.00
University of Oregon Medical School, Marquam Hill, Portland 1, Oregon	Obstetrics	1 week, Jan. 24-28, 1949	50.00
Oregon State Board of Health and Oregon State Medical Society, 11th and Salmon Sts., Portland 5, Ore.	Gynecology	5 days, April 11-15, 1949	50.00
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4	Refresher Lectures in Pediatrics and Obstetrics	3 hours pediatrics, 3 hours obstetrics, May 16-27, 1949 (tentative)	None
Dallas Southern Clinical Society, 433 Medical Arts Bldg., Dallas 1, Texas	Obstetrics-Gynecology	8 months, October-May, yearly	$40.00
Southwestern Medical College and Parkland Hospital, 2211 Oak Lawn Ave., Dallas 4, Texas	Obstetrics and Gynecology	3 days, Jan. 10-12, 1949	25.00
University of Texas School of Medicine Post-Graduate Division, 912 Avenue B, Galveston, Texas	Ob-Gyn Pathology and Clinical Review	Part time, 2 hours a week, October to May yearly	Not given
University of Wisconsin Medical School, 416 N. Randall St., Madison	Obstetrics	3½ days, March 21-26, 1949	25.00
	Observation Course in Obstetrics and Gynecology [18]	3-6 months, arranged	100.00 [6]
OPHTHALMOLOGY			
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	Ophthalmology	8 periods, 12 hours, begins Feb. 2, 1949, Wednesdays 8-9:30 p.m.	30.00
University of Florida, Department of Medicine Graduate School, 2031 Riverside Ave., Jacksonville, Fla. At: Miami, Fla.	Seminar in Ophthalmology and Otolaryngology	6 days, Jan. 10-12 (Ophthalmology) Jan. 13-15 (Otolaryngology)	40.00
The Children's Memorial Hospital, 707 Fullerton Ave., Chicago 14	Postgraduate Conference in Neuromuscular Anomalies of the Eyes [18]	6 days, May 1-6, 1949	50.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Four-week Course in Refraction Methods [19]	4 weeks, to be announced	275.00
	One-week Course in Ocular Fundus	1 week, full time, to be announced	75.00
	Two-week Intensive Course in Ophthalmology [18]	2 weeks, full time, to be announced	200.00
	Two-week Clinical Course in Ophthalmology	2 weeks or 4 weeks, available first of every week, except when other courses in Ophthalmology are in progress	50.00 100.00
	Part time Course in Ophthalmic Surgical Technique	5 weeks, one day each week, March 22	100.00
	Part time Course in Ophthalmoscopy of Common Conditions	3 weeks, one day each week, May 10	45.00
State University of Iowa, University Campus, Iowa City	Conference on Squint	6 days, May 23-28, 1949	150.00
Foundation for Vision, Inc., The Ophthalmological Study Council, 339 Commonwealth Ave., Boston 15 At: Portland, Maine	The Lancaster Courses sponsored by The Ophthalmological Study Council	2 months, 2 weeks, 2 days, June 25-Sept. 10, 1949	300.00
Harvard Medical School and Massachusetts Eye and Ear Infirmary, 25 Shattuck St., Boston 15 At: Harvard Medical School	Fundamentals in Refraction and Ocular Motility	1 month, daily, all day except Saturday afternoons, Jan. 31-Feb. 26, 1949	150.00
Tufts College Medical School Postgraduate Division, 39 Bennet St., Boston 11 At: Boston City Hospital At: Boston Dispensary	Neuroophthalmology	90 hours per week for two weeks or full time one week, March 14-26, 1949	75.00 [6] 5.00 [6]
	Ophthalmology	4 weeks, 3 mornings a week, Jan. 10-Feb. 4, 1949	75.00 [6] 5.00 [6]
	Ophthalmology	4 weeks, mornings only, May 2-27, 1949	50.00 [6] 5.00 [6]
University of Michigan Medical School Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich.	Ophthalmology Conference	3 days, March 7-9, 1949	25.00
University of Minnesota Center for Continuation Study, Minneapolis 14	Ophthalmology	5½ days, Jan. 24-29, 1949	To be announced
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Jewish Sanitarium and Hospital for Chronic Diseases	Ophthalmoscopy	6 weeks, part time, beginning April 1949	25.00

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Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
OPHTHALMOLOGY—Continued			
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York 32 At: Montefiore Hospital	Ophthalmology (PM-60) Ophthalmology (PM-61), Perimetry	2 months, once a week, two hours, Jan. 3-Feb. 28, 1949 2 months, once a week, two hours, March 14-May 9, 1949	50.00 50.00
At: Mt. Sinai Hospital	Symposium in Ophthalmology (Ophthalmology PM-43)	1 month, full time, April 25-May 21, 1949	200.00
New York Polyclinic Medical School and Hospital, 341 W. 50th St., New York 19	Ophthalmology, including Cadaver Courses and Refraction Ophthalmology, including Cadaver Ophthalmol. & Refraction Clinical Ophthalmology Clinical Ophthalmology Ophthalmology Ophthalmology	3 months, full time, April 4-Oct. 3, 1949 3 months, part time, April 4-Oct. 3, 1949 6 weeks, full time, April 4-Oct. 3, 1949 3 months, full time, April 4-Oct. 3, 1949 6 weeks, part time, April 4-Oct. 3, 1949 3 months, part time, April 4-Oct. 3, 1949	600.00 275.00 100.00 150.00 50.00 75.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Motor Anomalies of the Eye (B-1413, Part I) [16] Motor Anomalies of the Eye (B-1414, Part II) [16] Ophthalmic Neurology (A-1417) [16] Surgery of the Eye (B-1419) [16]	6 days, full time, March 7-12, 1949 5 days, full time, March 14-18, 1949 5 days, part time, Feb. 28-March 4, 1949 6 days, full time, March 21-26, 1949	100.00 75.00 50.00 100.00
New York University College of Medicine and National Society for Prevention of Blindness, New York At: New York University College of Medicine	Occupational Aspects of Ophthalmology	1 week, part time, Jan. 24-29, 1949	Not given
New York Post-Graduate Medical School, 303 E. 20th St., New York 3	Differential Diagnosis with the Slit Lamp (A-1421) [16]	5 days, part time, Feb. 28-March 4, 1949	75.00
University of Oregon Medical School, Oregon Academy of Ophthalmology and Otolaryngology, Portland	Oregon Academy Postgraduate Convention [16]	1 week, full time, March 1949	50.00
Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.	Spring Graduate Course in Ophthalmology, Otology, Rhinology, Laryngology, Facio-Maxillary Surgery, Bronchoscopy and Esophagoscopy [16]	1 week, full time, April 4-9, 1949	75.00 40.00 [15]
ORTHOPEDIC SURGERY			
George Washington University School of Medicine and Hospital, 1335 H St., Washington, D. C.	Bone and Joint Surgery	1 week, full time, March 28-April 1, 1949	50.00
Northwestern University Medical School, 303 E. Chicago Ave., Chicago 11	Bone and Joint Pathology	3 months, full time, Jan. 3-March 31, 1949	300.00
Tulane University of Louisiana School of Medicine, 1430 Tulane Ave., New Orleans, La.	Basic Science as Applied to Orthopedics	5 months, Feb. 1-June 30, 1949	300.00
Columbia University, 630 W. 168th St., New York 32 At: Hospital for Joint Diseases	Orthopedic Surgery PM-80, Survey of the Essentials of Orthopedics	2 months, once a week, all day, March 3-May 12, 1949	100.00
New York Medical College, Flower and Fifth Avenue Hospitals, 50 E. 106th St., New York	Anatomy for the Orthopedic Surgeon	160 hours, arranged	150.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Pathology in Relation to Orthopedic Surgery (C-161) Seminar in Orthopedic Surgery (B-500) [16] Orthopedics in General Practice (B-520) Functional Anatomy in Relation to Orthopedics (A-522)	12 weeks, part time, Feb. 8-April 26, 1949 10 days, full time, Jan. 3-14, 1949 6 days, full time, May 16-21, 1949 2 weeks, part time, Jan. 17-28, 1949	80.00 125.00 60.00 75.00
University of Oregon Medical School, Marquam Hill, Portland 1, Ore.	Orthopedic Surgery	5 days, May 23-27, 1949	50.00
OTOLARYNGOLOGY			
Georgetown University School of Medicine, 3900 Reservoir Rd., Washington 7, D. C.	Graduate Course in Otolaryngology and Bronchoscopy	2 weeks, April 18-30, 1949	150.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Informal Course in Otolaryngology Informal Course in Otolaryngology	2 weeks, full time, every week except when formal course in session 1 month, full time, every week except when formal course in session	50.00 100.00
University of Illinois Department of Otolaryngology, 1853 W. Polk St., Chicago 12	Two-week Intensive Course in Otolaryngology Didactic and Clinical Refresher Course in Otolaryngology	2 weeks, full time, April 4, 1949 Not given	200.00 150.00 [16]
University of Michigan Medical School, Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor	Otolaryngology Conference [16]	3 days, full time, March 10-12, 1949	25.00
Hansel Foundation, 1229 Missouri Theatre Bldg., St. Louis	Practical Allergy in Otolaryngology [16]	5½ days, May 30-June 4, 1949	150.00
New York Medical College, Flower and Fifth Avenue Hospitals, 50 E. 106th St., New York	Applied Anatomy for the Otolaryngologist	150 hours, arranged	275.00
New York Polyclinic Medical School and Hospital, 341 W. 50th St., New York 19	Clinical Otolaryngology Clinical Otolaryngology Otolaryngology, including Cadaver Courses and Refraction	6 weeks, part time, April 4, 1949 3 months, part time, April 4, 1949 3 months, full time, April 4, 1949	75.00 100.00 600.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Diagnostic Procedures in Otolaryngology (A-620) Symposium on Otolaryngology (B-630) [16]	Part time, any time there is vacancy 2 weeks, full time, April 25-May 7, 1949	40.00 [16] 150.00
University of Cincinnati College of Medicine, Eden and Bethesda Aves., Cincinnati 29	Operative Course in Otolaryngology [16]	1 week, April 28-30, 1949	125.00
University of Oregon Medical School, Oregon Academy of Ophthalmology and Otolaryngology, Portland	Oregon Academy Postgraduate Convention [16]	1 week, full time, March 1949	50.00
Gill Memorial Eye, Ear and Throat Hospital, 711 S. Jefferson St., Roanoke, Va.	Twenty-Second Annual Spring Graduate Course [16]	1 week, April 4-9, 1949	40.00 [15] 75.00
OTOLOGY			
Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.	Spring Graduate Course in Ophthalmology, Otology, Rhinology, Laryngology, Facio-Maxillary Surgery, Bronchoscopy and Esophagoscopy [16]	1 week, full time, April 4-9, 1949	75.00 40.00 [15]
OTORHINOLARYNGOLOGY			
Georgetown University School of Medicine, 3900 Reservoir Rd., N.W., Washington 7	Intensive Graduate Course	2 weeks, April 18, 1949	Not given
Indiana University School of Medicine, 1040 W. Michigan St., Indianapolis 7	Anatomical and Clinical Course in Otorhinolaryngology [16]	2 weeks, full time, April 2-15, 1949	$200.00
Manhattan General Hospital, 207 Second Ave., New York 3	Rhinoplasty and Otoplasty [16]	1 month, March 1949	$300.00
Virginia Society of Ophthalmology and Otolaryngology, Charlottesville	Ear, Eye, Nose and Throat	6½ months, Jan. 1-July 15, 1949	Not given
Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Va.	Spring Graduate Course in Ophthalmology, Otology, Rhinology, Laryngology, Facio-Maxillary Surgery, Bronchoscopy and Esophagoscopy [16]	1 week, full time, April 4-9, 1949	75.00 40.00 [15]

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Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	PATHOLOGY		
University of California School of Medicine, and University Extension, Los Angeles and San Francisco At: Los Angeles	Surgical Pathology [33]	Spring 1949	Not given
At: General Medical and Surgical Hospital, V. A. Center, Los Angeles	General Surgical Pathology Review	16 meetings, 2 hours each, March 1-April 21, 1949	60.00
		11 sessions, 2 hours each, Jan. 4-March 15, 1949	45.00
Yale University School of Medicine and Connecticut State Medical Society, New Haven At: Yale University School of Medicine	Pathology (200)	1 or 2 weeks, by appointment	15.00 [34]
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Special Courses in Surgical Pathology for Intensive Concentration in a Specific Field	10 weeks, part time, one day a week, April 13, 1949	100.00
	Personal Course in Pathology and Laboratory Medicine [18]	10 weeks, part time, one day a week, March 16, 1949	100.00
	Personal Course in Surgical Pathology, Gross & Microscopic [18]	10 weeks, part time, one day a week, March 21, 1949	75.00
	Course in Clinical Pathology	2 weeks, full time, every 2 weeks	150.00
	Personal Course in Surgical Pathology [18]	4 weeks, full time, every 2 weeks	250.00
	Personal Course in Surgical Pathology [18]	6 months, full time, by appointment	800.00
	Course in Gross and Surgical Pathology [18]	12 months, full time, by appointment	900.00
	Course in Gross and Microscopic Pathology [18]	12 months, full time, by appointment	500.00
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Gynecologic Pathology	3 months, part time, 1 afternoon a week, March 21-June 18, 1949	50.00
	Pathology of Children's Diseases	3 months, part time, 1 afternoon a week, March 21-June 18, 1949	50.00
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Surgical Pathology	3½ months, part time, Jan. 29-May 14, 1949	300.00
New York Medical College, Flower and Fifth Avenue Hospitals, 29 E. 106th St., New York	Clinical Pathology	26 hours, arranged	100.00
	Histology	16 weeks, half time, arranged	200.00
	Advanced Pathology for Pathologists	Varies according to need of applicant	Not given [35]
New York Polyclinic Medical School and Hospital, 341 W. 50th St., New York 19	Practical Laboratory Instruction in Pathology	Arranged	Arranged
New York University College of Medicine, 477 First Ave., New York 16 At: Lenox Hill Hospital	Histopathology for Gynecologists	6 weeks, part time, March 1-Apr. 8, 1949	50.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Pathology for Surgeons (C-158)	5 weeks, part time, Feb. 28-March 31, 1949	50.00
	Surgical Pathology (C-155) [18]	15 weeks, part time, March-June 1949	200.00
University of Utah School of Medicine, 2nd So. and University Sts., Salt Lake City 1	Surgical Pathology	Winter quarter 1949	50.00
	PEDIATRICS		
University of Colorado Medical Center, Colorado State Health Department and Colorado State Medical Society, Denver At: University of Colorado Medical Center	Medical Care of the Premature Infant	3 days, full time, April 7-9, 1949	10.00 Regis.
Yale University School of Medicine and Connecticut State Medical Society, New Haven, Conn.	Pediatrics (200)	12 sessions, 2 hours each, Jan. 6-March 24, 1949	60.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Formal Intensive Course in Pediatrics [18]	4 weeks, full time, April 4, 1949	150.00
	Pediatrics	4 weeks, full time, April 1949	150.00
	Informal Course in General Pediatrics	2 weeks, full time, first of every week except when formal course is in session	60.00
	Informal Course in General Pediatrics	1 month, full time, first of every week except when formal course is in session	100.00
Michael Reese Hospital Postgraduate School, 29th and Ellis Ave., Chicago 16	Recent Advances in Pediatrics	2 weeks, full time, May 16-28, 1949	100.00
University of Louisville School of Medicine and Kentucky State Medical Association, Louisville At: Louisville General Hospital	Intensive Refresher Course in Pediatrics	3 days, June 1949	25.00
Louisiana State University School of Medicine and Louisiana State Board of Health, New Orleans At: Bastrop, Minden, Natchitoches, Ruston	Diseases of Children in General Practice	12 hours, Jan. 10-13, 1949	None
	Diseases of Children in General Practice	12 hours, Feb. 14-17, 1949	None
At: Louisiana State University School of Medicine	Review of Pediatrics for Rural Physicians	5 days, full time, March 21-25, 1949	None
Tulane University of Louisiana School of Medicine, Division of Graduate Medicine, 1430 Tulane Ave., New Orleans 13	Review of Pediatrics [18]	5½ days, Feb. 7-12, 1949	30.00
Harvard Medical School, 25 Shattuck St., Boston 15 At: Massachusetts General Hospital	Pediatrics (1A)	4 months, full time, Feb. 1-May 31, 1949	400.00
Tufts College Medical School, Postgraduate Division, 416 Huntington Ave., Boston At: Boston Floating Hospital and Boston Dispensary	Pediatrics	2 weeks, full time, March 7-19, 1949	75.00 5.00 [4]
	Clinical Pediatrics	4 weeks, mornings, March 7-Apr. 2, 1949	60.00 5.00 [4]
University of Michigan Medical Department of Postgraduate Medicine, Ann Arbor	Pediatrics	3 days, April 13-15, 1949	20.00
University of Minnesota Medical School, Minneapolis 14 At: Center for Continuation Study	Pediatrics	3 days, Feb. 7-9, 1949	Not given
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Beth El Hospital	Pediatrics	3 days, April 7-9, 1949	Not given
	Clinical Pediatrics	5 weeks, part time, beginning April 1949	50.00
New York State Department of Health, Albany At: University of Buffalo School of Medicine	Intensive Refresher Course in Pediatrics for General Practitioners Participating in Child Health Programs	2 weeks, arranged, Spring 1949	Not given
Columbia University College of Physicians and Surgeons, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Clinical Pediatrics (PM-50)	9 weeks, part time, Feb. 1-April 12, 1949	90.00
New York Medical College, Flower and Fifth Avenue Hospitals, 29 E. 106th St., New York	Clinical Pediatrics	1 month, full time, all year	150.00
	Clinical Pediatrics	3 months, full time, all year	250.00
	Clinical Pediatrics	6 months, full time, all year	450.00
	Clinical Pediatrics	9 months, full time, all year	650.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Clinical Pediatrics (B-410)	4 weeks, full time, Jan. 3-29, 1949	125.00
	Clinical Pediatrics (B-410)	4 weeks, full time, March 7-April 1, 1949	125.00
	Clinical Pediatrics (B-410)	4 weeks, full time, May 2-28, 1949	125.00
	Practical Clin. Pediatrics (B-413)	4 weeks, full time, Jan. 31-Feb. 25, 1949	125.00
	Practical Clin. Pediatrics (B-413)	4 weeks, full time, April 4-30, 1949	125.00
	Practical Clin. Pediatrics (B-413)	4 weeks, full time, May 31-June 25, 1949	125.00

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	PEDIATRICS—Continued		
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	Review of Clin. Pediatrics (B-415)	6 days, full time, Feb. 14-19, 1949	60.00
	Review of Clin. Pediatrics (B-415)	6 days, full time, April 18-23, 1949	60.00
	Review of Clin. Pediatrics (B-415)	6 days, full time, June 13-18, 1949	60.00
At: Lenox Hill Hospital	Pediatrics (A-421)	8 weeks, part time, Tuesday and Friday, Jan. 4-Feb. 25, 1949	50.00
	Pediatrics (A-421)	8 weeks, part time, Tuesday and Friday, April 5-May 27, 1949	50.00
Southern Pediatric Seminar, Inc., Saluda, N. C.	Southern Pediatric Seminar	2 weeks, full time, July 18-30, 1949	25.00
University of Oregon Medical School, Marquam Hill, Portland 1, Ore.	Pediatrics	5 days, Feb. 14-18, 1949	50.00
Oregon State Board of Health and Oregon State Medical Society, 11th and Salmon Sts., Portland 5, Ore.	Refresher Lectures in Pediatrics and Obstetrics	3 hours pediatrics, 3 hours obstetrics, May 16-27, 1949 (tentative)	None
Meharry Medical College, 1005 18th Ave. North at Meharry Blvd., Nashville 8, Tenn.	Pediatrics	5 days, March 21-25, 1949	25.00
University of Texas School of Medicine, Postgraduate Division, 912 Avenue B, Galveston	Pediatrics	5½ days, April 11-16, 1949	25.00
University of Wisconsin Medical School, 418 N. Randall St., Madison	Observation Course in Obstetrics	2-6 months, arranged	250.00 [6]
	Postgraduate Course in Pediatrics	5 days, full time, March 14-18, 1949	25.00
	PHARMACOLOGY		
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Survey of Pharmacology	1 week, one hour, Jan. 3-March 19, 1949	15.00
	PHYSICAL MEDICINE		
Columbia University, 630 W. 168th St., New York 32 At: Columbia-Presbyterian Medical Center	Physical Medicine PM-1, Seminar in Physical Medicine	5 days, Feb. 14-Feb. 18, 1949	40.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Kings County Hospital	Physical Medicine	5 weeks, part time, beginning April 1949	20.00
Columbia University, 630 W. 168th St., New York 32 At: Columbia-Presbyterian Medical Center	Physical Medicine PM-100, Review of Physical Medicine	5 months, full time, Jan. 3-April 23, 1949	250.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Physical Medicine	4 weeks, arranged	100.00
Institute of Rehabilitation and Physical Medicine, and New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-1701, Rehabilitation and Physical Medicine	12 weeks, full time, Monday through Friday, 9-5 p.m., Jan. 3-March 25, 1949	200.00
		24 weeks, full time, Monday through Friday, 9-5 p.m., Jan. 3-June 17, 1949	400.00
University of Minnesota Center for Continuation Study, Minneapolis 14	Physical Medicine	3 days, March 28-30, 1949	To be announced
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4	Physical Medicine	8 months, October-May yearly	800.00
University of Texas School of Medicine, 912 Avenue B, Galveston, Texas	Physical Medicine	5 days, Feb. 28-March 5, 1949	15.00 [27]
			15.00 [28]
	Physical Medicine	1 week, March 7-11, 1949	25.00 [27]
			15.00 [28]
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26 At: Grace Hospital	Physical Medicine	1 afternoon, one week, March 21-June 18, 1949	35.00
	PHYSIOLOGY		
Yale University School of Medicine and Connecticut State Medical Society, 256 Church St., New Haven, Conn., and 333 Cedar St., New Haven 11, Conn. At: Yale University School of Medicine	Physiology 205, Brain Tumor Registry	Not given, arranged	65.00
The George Washington University Medical School and Hospital, 1335 H St., N.W., Washington 5, D. C.	Surgical Physiology	1 week, full time, March 7-11, 1949	50.00
University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12 At: Swedish Covenant Hospital	Clinical Physiology	18 weeks, one hour per week, Jan. 15-May 15, 1949	25.00
University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12	Clinical Physiology (Division of Basic Medical Science Course for Specialty Training)	6 hours per week, Winter quarters 2 hours per week, Spring quarters	100.00 [5]
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Altitude Physiology	1 hour, one week, March 21-June 18, 1949	15.00
	Blood	3 hours, one week, March 21-June 18, 1949	35.00
	Survey of Medical Chemistry	1 hour/week, March 21-June 18, 1949	15.00
	Intermediary Metabolism	1 hour/week, March 21-June 18, 1949	15.00
Columbia University, 630 W. 168th St., New York 32 At: Mount Sinai Hospital	Physiology of Water and Electrolyte Balance (Physiology PM-31)	2 months, part time, Feb. 2-April 8, 1949	40.00
New York Medical College, Flower and Fifth Avenue Hospitals, 30 E. 106th St., New York City	Physiology of the Cardiovascular System and Blood	1 month, part time, to be arranged	75.00
	Physiology of Respiration	1 month, to be arranged	75.00
	Physiology of Nervous System	2 weeks, to be arranged	50.00
	Physiology of Special Senses	1 month, to be arranged	75.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-342, Normal and Pathological Physiology, Functional and Chemical Aspects	10 days, full time, March 28-April 8, 1949	100.00
	A-304, Normal and Pathological Physiology, Functional and Chemical Aspects	Part time, Wednesdays, 9-11 a.m., Jan. 5-Feb. 23, 1949	30.00
	PHYSIOLOGICAL CHEMISTRY		
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Physiological Chemistry Seminar	1 hour, one week, March 21-June 18, 1949	15.00
	POLIOMYELITIS		
Georgia Warm Springs Foundation, Warm Springs, Ga.	Care of Acute and Convalescent Poliomyelitis	1 week, Jan. 3, April 4, 1949	None
D. T. Watson School of Physical Therapy, Lectsdale, Pa., and University of Pittsburgh School of Medicine At: D. T. Watson School of Physical Therapy	Recent Advances in Treatment of Poliomyelitis	4 days, full time, arranged	None
University of Wisconsin Medical School, 418 N. Randall St., Madison	The Diagnosis and Therapy of Infantile Paralysis	5½ days, full time, June 20-25, 1949	25.00
	PROCTOLOGY		
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	Proctology	10 periods, 20 hours, beginning Jan. 6, 1949, Thursdays 8-10 a.m.	50.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Practical and Didactic Course in Proctoscopy and Sigmoidoscopy	3 weeks, 1 day each week, Jan. 11, Feb. 1, March 15, April 19, May 24, June 21	50.00
Tufts College Medical School Postgraduate Division, 20 Bennet St., Boston 11 At: Boston Dispensary and Mount Auburn Hospital	Proctology I	6 days, full time, April 25-30, 1949	40.00 [3] 5.00 [4]
	Proctology II	4 weeks, full time	250.00 [3] 5.00 [4]
	Proctology III	1 month, mornings, Jan. 31-Feb. 26, Feb. 28-March 26, March 28-April 23, June 6-July 2, 1949	100.00 [3] 5.00 [4]

References will be found on page 1276.

Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	PROCTOLOGY—Continued		
University of Minnesota Center for Continuation Study, Minneapolis 14	Proctology	5½ days, May 22-May 28, 1949	To be announced
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Jewish Hospital	Proctology	6 weeks, part time, beginning April 1949	40.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Proctology	6 weeks, part time, April 4, 1949	75.00
	Proctology including Cadaver Proctology	6 weeks, part time, April 4, 1949	200.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	A-949, Proctology	8 weeks, part time, Mon. thru Fri. 10-12 m., Jan. 3-Feb. 25, April 4-May 21, 1949	125.00
	PUBLIC HEALTH		
University of Michigan, School of Public Health, 109 S. Observatory St., Ann Arbor, Mich.	School Health	4 months, Mon., Feb. 7-Fri., June 4, 1949	Not given
	Public Health Administration	4 months, Mon., Feb. 7-Fri., June 4, 1949	Not given
	Maternal and Child Health	4 months, Mon., Feb. 7-Fri., June 4, 1949	Not given
	Industrial Health	4 months, Mon., Feb. 7-Fri., June 4, 1949	Not given
	Epidemiology	4 months, Mon., Feb. 7-Fri., June 4, 1949	Not given
	Tuberculosis Control	4 months, Mon., Feb. 7-Fri., June 4, 1949	Not given
New York State Department of Health and Albany Medical College, 76 State St., Albany 1, N. Y.	Extension Course for Health Officers, Grade II	1 year, monthly, entrance at any time	30.00
University of North Carolina, School of Public Health, Chapel Hill, N. C.	Public Health	9 months, September-June 1949	100.00 [6]
Ohio Department of Health, Oberlin, Ohio	Orientation in Public Health Administration	1 to 3 weeks, full time, by special arrangement	None
Dept. Industrial Hygiene, School of Medicine, and Dept. Inoustrial Engineering of School of Medicine, University of Pittsburgh, 3941 O'Hara St., Pittsburgh At: University of Pittsburgh, School of Engineering At: University of Pittsburgh, School of Medicine	Industrial Hygiene Engineering	32 hours, beginning Feb. 1, 1949	20.00
	Industrial Toxicology	32 hours, beginning Feb. 1, 1949	20.00
	Fellowship in Industrial Medicine	18 months, full time, beginning any time	No fee [21]
	RADIOLOGY		
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Clinical Course in Roentgenology [19]	2 weeks or	70.00
		1 month starting third Monday every month	125.00
	Diagnostic Roentgenology	6 months, by appointment	500.00
	Clinical Interpretation of X-Ray Findings [18]	10 weeks, one day each week, March 17	80.00
	Clinical and Lecture Course in Roentgenology [19]	2 weeks, first Monday of every month	125.00
	Twelve month Course in X-Ray Diagnosis and Therapy [19]	12 months, by appointment	750.00
	X-Ray Therapy	1 week, by appointment	60.00
		2 weeks, by appointment	110.00
		1 month, by appointment	200.00
		2 months, by appointment	300.00
Tufts College Medical School Postgraduate Division, 39 Bennet St., Boston At: Pratt Diagnostic Hospital	Radiology	4 days, full time, May 10-13, 1949	30.00 [5] 5.00 [4]
University of Michigan Medical School Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich.	Diagnostic Roentgenology	5 days, April 19-22, 1949	30.00
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26 At: St. Mary's Hospital	Beginning Physics in Radiology	Jan. 3-March 19, 1949	15.00
Wayne University College of Medicine, 1516 St. Antoine St., Detroit At: Receiving Hospital At: Wayne County General Hospital	Medical X-Ray Conference	1 hour per week, March 21-June 13, 1949	15.00
	Medical X-Ray Conference	1 hour per week, March 21-June 13, 1949	15.00
Columbia University, 630 W. 168th St., New York 32 At: Columbia-Presbyterian Medical Center	Radiology PM 1, Radiological Physics [18]	2 months, twice a week, one hour, March 2-April 29, 1949	25.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Beth El Hospital At: Jewish Hospital At: Jewish Sanitarium and Hospital for Chronic Diseases	Roentgen Diagnosis	8 weeks, part time, beginning April 1949	80.00
	Cardiovascular Roentgenology	8 weeks, part time, beginning April 1949	80.00
	Clinical Radiology	10 weeks, part time, beginning April 1949	80.00
New York Medical College, Flower and Fifth Avenue Hospitals, 99 E. 106th St., New York City	Radium and Roentgen Therapy	6 weeks, half time, every 6 weeks except during July and August	150.00
	Diagnostic Roentgenology	6 weeks, half time, every 6 weeks except during July and August	150.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Radiology	3 months, April 4, 1949	200.00
New York University-Bellevue Medical Center Post-Graduate Medical Center, 477 First Ave., New York 16 At: Beth Israel Hospital At: Bellevue Medical Center	A-811, Roentgenology	9 weeks, part time, Tues. and Thurs., 2-4 p.m., April 5-May 26, 1949	60.00
	A-813, Diagnostic Radiology	12 weeks, part time, Mon., Wed., Fri., 4-6 p.m., March 7-May 27, 1949	100.00
	C-816, Radiobiology	20 weeks, part time, Feb. 3-June 16, 1949, Thursdays 4-6 p.m.	125.00
University of Oregon Medical School, Marquam Hill, Portland 1, Ore.	Radiology	5 days, March 28-April 1, 1949	50.00
The American College of Physicians, U. S. Army, U. S. Public Health Service, Veterans Administration, Atomic Energy Commission, and Armed Forces Special Weapons Project, 4200 Pine St., Philadelphia 4 At: U. S. Army Medical Center, Washington, D. C.	Medical Aspects of Nuclear Energy [12]	8 days, full time, Jan. 24-Feb. 1, 1949	60.00 [5] 80.00 [3]
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4	Radiology	9 months, October-May, yearly	600.00
Baylor University College of Medicine and Atomic Energy Commission, 500 Lincoln Ave., Houston 1, Texas	Medical Aspects of Radiobiology	4 hours weekly, Jan. 1-July 1, 1949	To be arranged
Marquette University School of Medicine, 561 N. Fifteenth St., Milwaukee	Application of Radioisotopes to Medicine	6 days, Jan. 11, 18 and 25, Feb. 1, 8 and 15, 1949	To be announced
Wisconsin Anti-Tuberculosis Association, 1015 N. Jefferson St., Milwaukee, Wis.	Essentials of Chest X-Ray Films and Their Interpretation	6 sessions, 1 day a week, each session lasting 2 hours; first class Jan. 5-Feb. 12, 1949; second class Feb. 19-March 25, 1949	None
	SURGERY		
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	Minor Orthopedic Surgery [19]	8 periods, 12 hours, Thursdays 8-9:40 p.m., April 7, 1949	30.00
University of California School of Medicine and University Extension, 405 Hilgard Ave., Los Angeles 24 At: General Med. and Surg. Hosp., V. A. Center, Los Angeles	General Orthopedic Surgery	6 weeks, full time, begins Jan. 31, 1949	150.00 [23]
	Surgical Pathology	Spring 1949	Not given
	General Surgical Pathology Review	16 meetings, 2 hours, March 1-April 12, 1949	60.00

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Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	SURGERY—Continued		
Yale University School of Medicine and Connecticut State Medical Society, 333 Cedar Street, New Haven 11, and 258 Church St., New Haven 10 At: Yale University School of Medicine	Surgery 201, Traumatic Surgery	12 sessions, 2 hours, Jan. 5-March 23, 1949	45.00
The George Washington University Medical School and Hospital, 1335 H St., N.W., Washington, D. C. (5)	General Surgery	7 weeks, full time, Feb. 21-April 8, 1949	350.00
	Abdominal Surgery	2 weeks, full time, March 14-25, 1949	100.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Part time Personal Course in Surgical Pathology, Gross and Microscopic	10 weeks, 1 day a week, March 14, 1949	100.00
American College of Surgeons, 40 E. Erie St., Chicago At: Rice Hotel Houston, Texas At: Edgewater Gulf Hotel, Edgewater Park, Miss. At: Hotel President, Kansas City, Mo. At: Statler Hotel, Buffalo At: Statler Hotel, Washington, D. C. At: Olympic Hotel, Seattle At: MacDonald Hotel, Edmonton, Alberta	Sectional Meeting	Not given, Jan. 14-15, 1949	Not given
	Sectional Meetings	Not given, Jan. 7-8, 1949	Not given
	Sectional Meetings	Not given, Feb. 11-12	Not given
	Sectional Meeting	Not given, March 21-22	Not given
	Sectional Meeting	Not given, March 15-16	Not given
	Sectional Meeting	Not given, April 21-22	Not given
	Sectional Meeting	Not given, April 12-13	Not given
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Surgical Technique with Practice, Clinical Surgery, Surgical Anatomy and Preoperative and Postoperative Management [13]	4 weeks, Feb. 7, March 7, April 4, May 2, June 6, July 11	300.00
	Personal Course in Esophageal Surgery [13]	1 week, June 13	150.00
	Personal Course in Breast and Thyroid Surgery [13]	1 week, June 27	150.00
	Personal Course in Surgery of the Colon and Rectum [13]	1 week, March 7, April 11, May 16, June 13	100.00
	Personal Course in Thoracic Surgery [13]	1 week, June 20	100.00
	Surgical Technique with Practice	10 weeks, one day each week, Feb. 23	300.00
	Clinical Surgery	10 weeks, one day each week, March 10	150.00
	Personal Course in Surgical Diagnosis, Preoperative and Postoperative Management	10 weeks, one day each week, April 6	100.00
	Personal Lecture Course with Discussion in General Surgery	10 weeks, one day each week, March 24	100.00
	Esophageal Surgery	10 weeks, one day each week, March 8	150.00
	Treatment of Varicose Veins	2 weeks, one day each week, first and third Wednesdays each month	40.00
	Personal Course in Thoracic Surgery	10 weeks, one day each week, April 6	100.00
	Personal Course in Gallbladder Surgery	1 week, May 2, June 20	100.00
	Treatment of Varicose Veins	10 hours, one week, starts every Monday	40.00
	Course in Fractures and Traumatic Surgery	2 weeks, April 18, June 13	125.00
	Surgical Anatomy on the Cadaver and Clinical Surgery	2 weeks, Feb. 21, March 21, April 18, May 16, June 20, July 25	150.00
	Surgical Technique with Practice	2 weeks, Jan. 24, Feb. 21, March 21, April 18, May 16, June 20, July 25	200.00
	Intensive Review Course Considering Basic Principles in General Surgery	2 weeks, full time, April 4	200.00
Michael Reese Hospital Postgraduate School, 29th and Ellis Ave., Chicago 16	Recent Advances in Surgery	1 week, full time, May 2-7, 1949	50.00
Northwestern University Medical School, 303 E. Chicago Ave., Chicago 11	Basic Surgery	3 months, full time, April 1-June 30, 1949	300.00
American Trudeau Society, 1790 Broadway, New York 19 At: University of Indiana School of Medicine, Indianapolis	Postgraduate Course (Chronic Surgery)	1 week, March 7-12, 1949	Not given
Tulane University School of Medicine, Division of Graduate Medicine, 1430 Tulane Ave., New Orleans 12	Review of General Surgery and Traumatology	5½ days, Jan. 10-15, 1949	30.00
Tufts College Medical School Postgraduate Division, 39 Bennet St., Boston 11 At: Eisbird Research Laboratories	Principles of Surgical Technique	6 weeks, part time, May 31-July 8, 1949	200.00 [9] 5.00 [4]
University of Michigan Medical School Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich.	Clinical Exercises for Practitioners	25 days, Oct. 20, 1948-May 4, 1949 (Wednesdays), 25 days	50.00
Wayne University College of Medicine, 1512 St. Antoine St., Detroit 26	Surgery Seminar	1 hour, one week, March 21-June 18,	15.00
University of Minnesota Center for Continuation Study, Minneapolis 14	General Surgery	2 days, May 9-11, 1949	To be announced
Columbia University, 630 W. 168th St., New York 32 At: Affiliated Hospital	Surgery PM 180, Recent Developments in Surgery	5 days, full time, May 16-20, 1949	50.00
New York Medical College, Flower and Fifth Avenue Hospitals, 50 E. 106th St., New York City	Thoracic Surgery	3 weeks, full time, Spring semester	325.00
	Surgical Technique	50 hours, to be arranged	375.00
New York Polyclinic Medical School and Hospital, 341-353 W. 50th St., New York 19	Combined Surgical Course including Cadaver Surgery and Gynecology	3 months, full time, April 4, 1949	350.00
	Clinical Surgery	6 weeks, full time, April 4, 1949	100.00
	Clinical and Operative (Cadaver) Surgery	6 weeks, full time, arranged	200.00
New York Post-Graduate Medical School, 477 First Ave., New York 16	B-356, Diagnosis and Treatment of Trauma	6 days, full time, May 9-14, 1949	60.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16 At: Beekman-Downtown Hospital	B-356, Basic Course in Traumatic Surgery [13]	6 weeks, full time, May 16-June 24, 1949	300.00
	B-360, Seminar in Traumatic Surgery [13]	2 weeks, full time, March 7-19, 1949	125.00
	B-901, Review of General Surgery for Surgeons [13]	4 weeks, full time, April 4-30, 1949	300.00
	B-994, Recent Advances in Surgery	10 days, full time, March 7-17, 1949	175.00
	Surgery of Trauma A-370	10 weeks, part time, Thursdays 1-5 p.m., April 7-June 9, 1949	150.00
University of Oregon Medical School, Marquam Hill, Portland 1, Ore.	General Surgery	5 days, March 7-11, 1949	50.00
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4	Oral Surgery and Anesthesia	8 months, October-May, yearly	800.00
	Surgery	8 months, October-May, yearly	800.00
Washington State Medical Association, 327 Cobb Bldg., Seattle 1 At: Harborview Hospital	General Surgery	5 days, March 7-11, inclusive	25.00
University of Wisconsin Medical School, 418 N. Randall Ave., Madison	Observation Course in Surgery [13]	2-6 months, arranged	100.00 [9]

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Postgraduate Courses for Practicing Physicians—January 1, 1949 to July 15, 1949—Continued

Institution	Title of Course	Schedule of Course	Registration Fee and/or Tuition
	THERAPY		
Yale University School of Medicine and Connecticut State Medical Society, 333 Cedar St., New Haven 11, and 258 Church St., New Haven 10 At: Yale University School of Medicine	Therapeutics 200, Modern Drugs and Common Problems in Therapy	18 sessions, 2 hours each, Feb. 1-May 31, 1949	35.00
The George Washington University School of Medicine and Hospital, 1335 H St., N.W., Washington 5, D. C.	Therapeutics	1 week, full time, Jan. 31-Feb. 4, 1949	50.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16 At: Jewish Sanitarium and Hospital for Chronic Diseases	Clinical Therapeutics	7 weeks, part time, beginning April 1949	60.00
University of Oregon Medical School, Marquam Hill, Portland 1, Ore.	Applied Therapeutics	5 days, March 14-18, 1949	50.00
University of Utah, 2nd South and University Sts., Salt Lake City 1	Recent Advances in Therapeutics	Spring quarter (tentative)	Not given
	UROLOGY		
College of Medical Evangelists, Boyle and Michigan Aves., Los Angeles 33	General Urology	9 periods, 13½ hours, beginning Jan. 5, 1949, Wednesdays 6-9:30 p.m.	35.00
Cook County Graduate School of Medicine, 427 S. Honore St., Chicago 12	Ten day Practical Course in Cystoscopy	10 days, Jan. 10, Jan. 24, Feb. 7, Feb. 21, March 7, March 21, April 4, May 2, May 16, June 6, June 20, July 11, July 25	150.00
	Two week Course in Genito-urinary Surgery	2 weeks, April 18	225.00
American Urological Association, Central Committee on Graduate Instruction, 869 Madison Ave., Memphis 3, Tenn. At: New Orleans, La.	Graduate Course of Instruction, Southeastern Section, American Urological Association	5 days, 4 hours, March 1949	50.00
Detroit Urological Society, University of Michigan Medical School Department of Postgraduate Medicine, 1313 E. Ann St., Ann Arbor, Mich. At: University Hospital, Ann Arbor, Mich.	Urology Conference	2 days, Jan. 19-20, 1949	15.00
Joint Committee on Post-Graduate Education, Medical Society of the County of Kings, Long Island College of Medicine, 1313 Bedford Ave., Brooklyn 16	Urology	1 month, part time, begins April 1949	50.00
American Urological Association, Central Committee on Graduate Instruction, 869 Madison Ave., Memphis 3, Tenn. At: Buffalo, New York	Postgraduate Urological Seminar	5 days, 6 hours, Jan. 3-8, 1949	50.00
Department of Urology, James Buchanan Brady Foundation of the New York Hospital, 525 E. 68th St., New York	Postgraduate Course in Urology	31 weeks, Jan. 1, 1949	300.00
New York Medical College, Flower and Fifth Avenue Hospitals, 20 E. 106th St., New York City	Anatomy of the Urogenital System	120 hours, to be arranged	300.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16 At: Beth Israel Hospital	A-1028, Urology	6 weeks, part time, Mon.-Sat. 8:30-11 a.m., Tues. and Thurs. 2:30-4:30 p.m., Jan. 17-March 26, April 18-May 28, 1949	100.00
New York University-Bellevue Medical Center Post-Graduate Medical School, 477 First Ave., New York 16	B-1010, Advanced Course in Urology [19]	2 months, full time, Jan. 3-Feb. 28, 1949	200.00
University of Cincinnati College of Medicine and Society of General Physicians, Eden and Bethesda Aves., Cincinnati 29	Office Gynecology and Urology	6 sessions, 10-12 a.m., each Tuesday and Thursday mornings thru month of May	15.00
University of Pennsylvania Graduate School of Medicine, 237 Medical Laboratories, Philadelphia 4	Urology	8 months, October-May yearly	200.00
	VENEREAL DISEASE		
U. S. Public Health Service and Arkansas State Board of Health, Hot Springs National Park, Ark.	Postgraduate Venereal Disease Training Course	1 week, April 1949 and October 1949 of each year	None
University of Michigan School of Public Health, Ann Arbor, Mich.	Venereal Disease Control	2 weeks, Spring 1949	Not given
	Venereal Disease Control	Not given	Not given
Bureau of Social Hygiene, Department of Health, New York City	Postgraduate Course in Diagnosis and Treatment of Venereal Diseases	15 sessions, Fall 1948, Spring 1949	None
	Practical Seminar in Diagnosis, Treatment and Control of Venereal Disease	2 mornings a week, optional, all year round	None
University of Pennsylvania School of Medicine, the U. S. Public Health Service Institute for the Study of Venereal Disease, 237 Medical Laboratories, Philadelphia 4	Essential Basic Training Course	6 months, not given	Arranged $50.00
	Intensive Review Course	4 weeks, full time, not given	Arranged $50.00
	Refresher Course in Venereal Disease Control	10 days, not given	Arranged $50.00
	Venereal Disease Review Course	3 weeks, not given	Arranged $50.00
	Staff Assistantships as Part of Fellowships in Dermatology and Syphilology	Not given	Arranged $50.00

1. Members.
2. Non-members.
3. Tuition.
4. Registration.
5. Per quarter.
6. Per month.
7. $25.00 for two weeks.
8. Third week additional $65.
9. $75 for two weeks, $125 for one month.
10. Per week.
11. One day a week for 20 weeks group—the latest possible date for entrance into this group will be Friday, Feb. 11, 1949.
12. For interns.
13. Chicago Medical Society, members free, non-members $5.00.
14. Paid by Council of Rochester Regional Hospitals.
15. For half course.
16. Clinical neurology, Jan. 3-Feb. 28; psychiatry, March 7-May 2; analytic psychology-psychopathology, Jan. 14 and 28, Feb. 11 and 25, March 11 and 25; Pediatrics 201, pediatric neurology, April 4-29, 1949.
17. Open to qualified clinical psychiatrists and psychologists.
18. Specialists only.
19. Advanced candidates in training.
20. Full maintenance.
21. Maintenance not provided.
22. Students with one basic course in Rorschach.
23. For those without training in psychoanalysis.
24. For those with some training in psychoanalysis.
25. For all courses.
26. Plus $10.00 lab. fee.
27. M.D.'s, $25.
28. Registered physical therapists, registered occupational therapists, $15.
29. Technicians, $15.
30. Specialists who have taken 1413.
31. No fee. Fellowship honorarium $250 per month.
32. Each section (3 sections, a, b and c). May take one or more sections.
33. This course is designed especially for those surgeons preparing for the second part of the examination by the American Board of Surgery.
34. Per hour.
35. This course is available only to physicians certified by American Boards.
36. No charge for room and board.
37. Open to M.D.'s from medical schools approved by Council on Medical Education and Hospitals of the American Medical Association who have had at least one year of acceptable training in physiology, neurology or psychiatry.
38. There may be a nominal registration fee.
39. Per year.
40. Open to Hospital Administrators.
41. Members of Local Medical Profession.
42. No charge to medical officers of the participating agencies.
43. Per semester.

Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1937 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted below.

American J. Obstetrics and Gynecology, St. Louis

56:205-408 (Aug.) 1948. Partial Index

Further Studies on Electrical Potentials of Human Uterus in Labor. L. V. Dill and R. M. Maiden.—p. 213.
*Microscopic Observations of Placental Barrier in Transplacental Erythrocytotoxic Anemia (Erythroblastosis Fetalis) and in Normal Pregnancy. B. S. Kline.—p. 226.
Progressive Resistance Exercise in Functional Restoration of Perineal Muscles. A. H. Kegel.—p. 238.
*Intestinal Changes Secondary to Irradiation of Pelvic Malignancies. J. M. Maas.—p. 249.
Tissue Localization and Excretion Routes of Radioactive Dibromostrone. G. H. Twombly, L. McClintock and M. Engelman.—p. 260.
Effects of Various Estrogenic Preparations on Vaginal Mucosa. Mildred Vogel, T. H. McGavack and J. Mellow.—p. 269.
Role of Uterine Motility in Essential Dysmenorrhea. W. K. Diehl and J. M. Hundley Jr.—p. 281.
Outcome of Pregnancy Following Vaginal Operations. W. F. Finn.—p. 291.
Solid Teratoma of Ovary, with Report of 5 Cases. E. R. Novak.—p. 300.
Thecа-Cell Tumors of Ovary with Report of 15 Cases and Review of Literature. W. R. Knight III.—p. 311.
Smear Diagnosis of in Situ Carcinoma of Cervix. F. W. Foote and Katherine Li.—p. 335.
*Retreatment of Pregnant Woman for Syphilis Following Penicillin. Is Additional Therapy Necessary When Effective Treatment Has Been Given Prior to Conception. N. R. Ingraham Jr., Elizabeth Kirk Rose, J. H. Stokes, and others.—p. 340.
Prediction of Day of Human Ovulation by Rat Test as Confirmed by Fifty Conceptions. E. J. Farris.—p. 347.
Vaginal Delivery Under Heavy Pentocaine Spinal Anesthesia. R. E. Ahearn and J. W. Huston.—p. 353.
Vaginal Cytologic Survey in Gynecologic Cancer. V. Parrett, C. Small and L. Winn.—p. 360.
Shock from Posterior Pituitary Extract. A. E. Kanter and A. H. Klawans.—p. 366.
Breech Presentation and Delivery: Review of 445 Consecutive Cases in General Hospital. H. Meyer.—p. 375.

Microscopic Observations of Placental Barrier.—On microscopic examination of placentas from 15 patients with erythroblastosis fetalis Kline found in all numerous breaks in the barrier associated with hemorrhage from the fetal circulation into the maternal intervillous spaces. Nucleated red blood cells of the fetus were observed in areas of recent hemorrhage in the regional intervillous spaces. The breaks in the placental barrier involved the surface and villi and trunks and apparently resulted from the occlusion of peripheral capillaries or larger vessels by agglutinated red blood cells and fibrin. Regional to the areas of vascular occlusion, the overlying epithelium showed degenerative or necrotic change and in places erosion associated with hemorrhage from the fetal circulation into the regional intervillous spaces. Coincidentally, access of maternal blood to the fetal circulation was afforded. The mixture of bloods is stopped quickly, apparently by the formation of a clot at the site of injury. Since the erythroblastosis is a secondary manifestation, the designation "erythroblastosis fetalis" is no longer justified. Furthermore, it was found that destruction of the incompatible fetal red blood cells in the disease occurs in part by phagocytosis. The term "congenital hemolytic anemia," therefore, is not entirely accurate and "transplacental erythrocytotoxic anemia" is suggested as a better name for the disease. Microscopic examination of the placentas in 213 cases in the last half of the normal pregnancy showed in the barrier in all numerous breaks of the same type as observed in the cases of erythroblastosis fetalis. The demonstration of numerous breaks in the placental barrier in erythroblastosis fetalis in the last half of pregnancy adds evidence confirming the studies of Levine, which established erythroblastosis fetalis as a disease caused by the destruction of fetal red blood cells by antibodies produced in the mother to some incompatible factor within the fetal red blood cells.

Intestinal Changes Following Irradiation of Pelvic Cancers.—Maas reviewed 600 cases in which irradiation was used for cancers in the pelvic area. There were 523 cases of radiation sickness and 70 cases in which permanent rectal changes developed. Onset and course of radiation sickness are unpredictable and their management unsatisfactory. Higher doses of radiation therapy tend to produce permanent rectal lesions earlier and of a more serious nature. Radium is a more serious offender than are roentgen rays. Factitial proctitis makes up the bulk of permanent rectal changes secondary to irradiation of the pelvis for pelvic cancers. The region of the rectosigmoid junction is most frequently involved by factitial proctitis. Colostomy is employed to check excessive bleeding or relieve obstructions. The results obtained frequently are negligible. Rectal stenosis following radiation to pelvic cancers occurred forty-eight times in the 600 cases. The process is irreversible. One case of fibrosis without stricture was encountered. Rectovaginal fistula, which occurs secondarily to metastatic invasion of the bowel and devitalization of tissue in the rectovaginal septum, developed in 13 cases. Secondary carcinoma of the bowel occurred in 10 cases. One primary adenocarcinoma of the rectum developed in a case of squamous cell carcinoma of the cervix.

Retreatment of Pregnant Woman for Syphilis.—Ingraham and his associates say that in a group of 52 mothers treated for syphilis with penicillin before but not during pregnancy, 46 apparently normal and no syphilitic living infants resulted. The three abortions, one miscarriage, one stillbirth and one neonatal death which occurred could not be attributed to syphilis, and probably resulted from other causes. Speiser and his co-workers recently found 1 syphilitic infant among 84 similarly studied pregnancies. Syphilis occurred in this infant when a mother who was delivered nine months after being treated for symptomatic early syphilis was not adequately observed during pregnancy and was subsequently found to have an abnormal response to therapy. Under the ideal antepartum care which dictates monthly physical examination and blood serologic test for the woman once syphilitic, it is apparently safe to permit the expectant mother to go untreated during her pregnancy, assuming normal response to treatment. Retreatment of the syphilitic pregnant woman should be instituted if the clinical or laboratory response is not normal, or in circumstances in which there is some risk of infection of the fetus and anticipated antepartum care may fall below the optimum. The authors do not feel that final conclusions can be drawn from a short period of observation of the limited material collected, but they hope that such a report may serve as a stimulus to the collection of additional data which in the aggregate may give a definite answer to the question of re-treating the syphilitic woman because of pregnancy, when she has had an acceptable course of penicillin for this disease prior to conception.

American Journal of Psychiatry, New York

104:673-752 (May) 1948

Effect of Thyroid Therapy on Conditional Reflex Function in Hypothyroidism. W. H. Gantt and W. Fleischmann.—p. 673.
Combined Insulin Coma and Electric Convulsive Therapy in Schizophrenia. W. A. Horwitz and L. B. Kalinowsky.—p. 682.
Psychopharmacologic Study of Schizophrenia and Depression: IV. Influence of Electric Convulsive Therapy on Sodium Amytal Response of Electroencephalogram. J. S. Gottlieb, J. R. Knott and L. L. Kimble.—p. 686.
Cerebrospinal Fluid Changes in Electroshock Treatment of Psychoses: Spectrophotometric and Enzyme Studies. M. Spiegel-Adolf, P. H. Wilcox and E. A. Spiegel.—p. 697.
Effect of Electric Shock on Mental Efficiency. P. E. Huston and C. R. Strother.—p. 707.
Somatotypes in Relation to Dementia Praecox. L. Bellak and R. R. Holt.—p. 713.
Frequency of Syphilitic Primary Optic Atrophy in Dementia Paralytica: Clinico-Anatomic Study. W. L. Brustsch.—p. 725.
Clinical Significance of Rorschach Test. C. E. Johnson Jr. and J. E. Sherman.—p. 730.

Anesthesiology, New York

9:345-458 (July) 1948. Partial Index

Hemolytic Transfusion Reactions. M. J. Nicholson.—p. 345.
Neb Piperidine Derivatives as Local Anesthetics. C. L. Rose, T. P. Carney and K. K. Chen.—p. 373.
Anesthetic Management of Patients with Fracture of Mandible. S. G. Hershey and E. A. Rovenstine.—p. 381.
Music as Supplement in Nitrous Oxide-Oxygen Anesthesia. H. Cherry and I. M. Pallin.—p. 391.
Trends in Regional Anesthesia. C. S. Hellijas and R. M. Tovell.—p. 400.
Endobronchial Anesthesia by Means of Improved Endobronchial Airway. H. S. Ruth, D. D. Grove and K. K. Keown.—p. 422.
Evaluation of Monocaine Formate in Production of Low Spinal Anesthesia. R. M. Nesbit and W. J. Butler.—p. 430.
Spinal Anesthesia with Procaine-Pontocaine Solution: 100 Cases. F. W. Marvin.—p. 434.

Bulletin of Johns Hopkins Hospital, Baltimore

83:119-186 (Aug.) 1948

Nitrogen Metabolism of Gram-Positive Bacteria. E. F. Gale.—p. 119.
*Sulfhydryl Compounds and the Sickling Phenomenon: Preliminary Report. L. Thomas and C. A. Stetson Jr.—p. 176.

Sulfhydryl Compounds and the Sickling Phenomenon.—According to Thomas and Stetson the methods which are in current use for the routine laboratory diagnosis of sickle cell disease are based on the widely accepted concept that the sickling phenomenon is brought about by the reduction of hemoglobin in the red cell. The authors studied the effect of a variety of reducing agents on sickle cells with the purpose of devising a dependable means for the rapid diagnosis of sickle cell disease. It was found that sulfhydryl compounds, notably hydrogen sulfide, BAL (2,3-dimercaptopropanol) and cysteine, caused complete sickling within less than a half hour. It is suggested that sulfhydryl compounds may be of value in the laboratory diagnosis of sickle cell disease because of the rapidity with which reliable and reproducible results can be obtained.

Endocrinology, Springfield, Ill.

42:427-494 (June) 1948

Effect of Methylthiouracil on Oxygen Consumption of Thyroid, Liver and Kidneys. U. Borell and H. Holmgren.—p. 427.
Hyperuricemia in Mice Bearing Granuloma Cell Growth; Time of Onset and Some Associated Physiologic and Chemical Changes. H. Schöl and J. Furth.—p. 436.
Effect of Ultraviolet Irradiation on Biologic Activity of alpha-Estradiol Benzoate. J. J. Trentin and C. W. Turner.—p. 448.
Histologic Observations on Relation of Insulin to Deposition of Glycogen in Adipose Tissue. D. W. Fawcett.—p. 454.
Plasma Inorganic Iodide, a Chemical Regulator of Normal Thyroid Function. J. Wolff and I. L. Chaikoff.—p. 468.
Effect of Partial Hepatectomy on in Vivo Activation of Triphenyl-Chloroethylene. A. Segaloff.—p. 472.

Hawaii Medical Journal, Honolulu

7:447-544 (July-Aug.) 1948

*Epidemiological Significance of Behavior of Poliomyelitis in Warmer Climates. W. L. Aycock.—p. 461.
*Sudden Death in Filipino Men: Unexplained Syndrome. A. V. Majoska.—p. 469.
Intra-Uterine Fetal Asphyxia. C. C. McCorriston.—p. 474.
Adoption: Complex Community Responsibility. M. A. Busch.—p. 477.

Poliomyelitis in Warmer Climates.—According to Aycock, the spread of the virus of poliomyelitis is extensive and is the result of ordinary, unavoidable and probably irreducible contact. Infection with this virus is preponderantly benign, the one serious sequel of infection, paralysis, occurring in only a small fraction of those exposed. In the tropics the evidence indicates that in terms of parasitism adaptation between virus and host is even more nearly balanced. Widespread exposure to the virus, more frequently during the persistence of equally widespread maternal immunity, apparently results in more frequent modified infection, but still with propagation of virus, with resultant active immunity to be passed on to the offspring for repetition of the cycle. Thus in warm climates a high degree of commensalism with the virus has been attained. In poliomyelitis there are a number of selectivities seen in the occurrence of paralytic disease in the few of them exposed to the virus which indicate that this "complication" of the ordinarily subclinical infection is determined primarily not by circumstances of exposure to the virus but by autarceologic influences. The mechanism through which a lower incidence of paralysis occurs in warmer climate seems to be the operation in nature of the principle of variolation rather than the principle of vaccination. It is suggested that the virus of poliomyelitis requires host conditions of warm weather or warm climate both for disease production and for multiplication and hence propagation. Such a conception, under which this virus could be active for only a brief part of the year in more temperate climates and throughout the year in warmer climates, could account for the more rapid and extensive dissemination of the virus in warmer climates.

Sudden Death in Filipino Men.—Majoska reports the occurrence of sudden death in 81 young Filipino men. There were 51 such deaths in the years 1937 to 1944 and 30 from 1945 to 1948, with no particular seasonal occurrence. The highest incidence of these deaths was observed between the ages of 30 and 34 years. There was a consistent lack of exposure to noxious industrial substances in practically all cases. The men retired in apparently the best of health and died sometime during the night. The one person dying in the day time was one who worked at night and died at noon in his sleep. The death is usually preceded by sounds of gasping, groaning, moaning or choking. Cyanosis, generalized visceral congestion, subpleural and subpericardial petechial hemorrhages were revealed on necropsy. Acute hemorrhagic pancreatitis was the chief postmortem observation, but it is not known whether this was cause or effect. Frequently the stomach is dilated by a large amount of partially digested food. Food, poisons, supernatural forces, intestinal parasites, hypoglycemia and reflex shock possibly initiated by sudden fright or nightmare have been suggested as possible causes but have been fairly well eliminated. The syndrome apparently does not affect women or men of other races.

Journal of Gerontology, Springfield, Ill.

3:87-180 (April) 1948

Aging and Calcification of Human Coronary Artery. A. I. Lansing, H. T. Blumenthal and S. H. Gray.—p. 87.
Acid Phosphatase Concentration of Prostatic Fluid in Young, Middle-Aged, and Old Individuals. E. Kirk.—p. 98.
Aneurysms of Iliac Arteries. Mary C. Long.—p. 105.
Liver Cirrhosis in Aged. J. Boch.—p. 111.
Serum Protein Fractionation in Normal Old Individuals. J. Boch.—p. 119.
Kidney in Old Age: Preliminary Communication. T. H. Howell and A. P. Piggot.—p. 124.
Community Planning for the Aged: Outline of Working Hypothesis. Hertha Kraus.—p. 129.

Journal of International College of Surgeons, Chicago

11:343-442 (July-Aug.) 1948

*Prefrontal Lobotomy: Complications and Their Treatment. J. W. Watts and W. Freeman.—p. 343.
*Theoretical and Clinical Aspects of Vagotomy. F. Mandl.—p. 351.
Recent and Old Fractures of Internal Malleolus. J. J. Callahan.—p. 354.
Anterior Capsulectomy for Contractures of Elbow. P. Willner.—p. 359.
Infections of Extremities. C. J. Bellis.—p. 363.
Preoperative and Postoperative Care in Carcinoma of Rectum and Pelvic Colon. J. P. Fleming.—p. 378.
Postpartum Dissection and Repair of Preexisting Perineal Relaxation. A. P. Hudgins.—p. 386.
Epithelization Time After Gastrectomy. K. Katrakis and A. Karteosis.—p. 392.
Clinical Evaluation of New Technic in Sclerotherapy of Varicose Veins. E. J. Orbach.—p. 396.
Pseudocysts of Pancreas and External Drainage. F. M. Berkay.—p 403.
Evaluation of Gastroscopy in Study of Cancer of Stomach. W. E. Ricketts.—p. 425.

Prefrontal Lobotomy.—Watts and Freeman performed prefrontal lobotomy on 531 mental patients with only 12 operative deaths (2.3 per cent). Secondary operations were performed in 70 cases with no operative death. This brings the total number of operations up to 610 with an operative mortality slightly under 2 per cent. Prefrontal lobotomy is a simple but precise operation. It has been necessary to terminate the operation before completion in only 4 cases. Incontinence and inertia occur in almost every patient and constitute the main nursing problems during the short hospital stay. Excitement is rare. Operative hemorrhage was sufficient to require enlargement of

the bony opening to control it in 6 patients. Hemiparesis developed in 4 and proved permanent in 2. Chronic intracerebral hematoma developed in 3 patients and a hygroma in 1. Hemorrhage was the cause of death in 3 patients operated on (0.5 per cent). Convulsions are the most embarrassing sequela of prefrontal lobotomy and occurred in 66 (12.3 per cent) of the authors' patients. Further analysis revealed that 7.2 per cent had attacks after a single operation, but 47 per cent developed convulsions after secondary operations. A majority can be controlled by anticonvulsive therapy. Although the patient does not complain, morphine withdrawal symptoms may be severe when the drug is withheld after lobotomy.

Vagotomy.—Mandl performed vagotomy by the subdiaphragmatic route on 101 patients with ulcers of the stomach, pylorus, duodenum and jejunum and anastomotic recurrences after resection. Sixty-nine patients had ulcers of the pyforus and duodenum. In 13 the operation was combined with gastrojejunostomy. In all cases the roentgen findings cleared up after vagotomy. Twelve cases were complicated by severe coronary and heart disease, chronic lung disease, epilepsy, thyrotoxicosis, megacolon and pregnancy; in no case was the complicating condition aggravated by vagotomy. Only 1 of the 101 patients operated on, most of them poor risks, died on the tenth postoperative day of causes unrelated to the operative procedure. Gastric and intestinal atony could be controlled with ease. Twenty-five patients sooner or later had diarrhea. All patients were relieved after some weeks or days of treatment with opiates, betaine hydrochloride with pepsin or sulfonamide compounds. Examination of the diastase level in the urine and the blood sugar level in 20 patients showed that the diastase rose postoperatively to values on an average of 1:128 in all patients, while the blood sugar level rose only in 10. Diastase levels returned to normal after five to nine days, and blood sugar levels after five days. On the basis of the balance between vagal and sympathetic innervation of the stomach a new test was developed demonstrating that all vagal fibers are cut; the assumption is that if vagotomy is complete no rise in gastric acidity will occur after sympathetic block. The author believes that vagotomy will in time have a solid place in the surgery of peptic ulcer.

Journal of Nat. Cancer Inst., Washington, D. C.

8:201-241 (April-June 1948). Partial Index

Histopathologic Study of Mode of Inhibition of Cellular Proliferation by Urethane: Effect of Urethane on Wound Healing. C. C. Lushbaugh, J. W. Green Jr. and J. B. Storer.—p. 201.
Mammary Tumors in Mice Presumably Free of Mammary-Tumor Agent. H. B. Andervont and Thelma B. Dunn.—p. 227.

Journal of Pediatrics, St. Louis

33:141-266 (Aug.) 1948

*Antibody Formation in Early Infancy Against Diphtheria and Tetanus Toxoids. Jean V. Cooke, Jean Holowach, J. E. Athias Jr. and J. R. Powers.—p. 141.
Galactosemia. E. O. Goldstein and J. M. Ennis.—p. 147.
Study of Physical Activity in Juvenile Diabetic Patients. R. L. Jackson and Helen G. Kelly.—p. 155.
Graphs of Head Circumference of Normal Infants. H. K. Silver and W. C. Dreamer.—p. 167.
Arthritis, Conjunctivitis and Urethritis (So-Called Reiter's Syndrome) in Four-Year-Old Boy. A. L. Florman and H. M. Goldstein.—p. 172.
Para-Aminobenzoic Acid Blood Levels. R. D. Lomas and G. W. Salmon.—p. 178.
*Incidence of Sickle Cell Anemia with Rheumatic Heart Disease. I. R. Ohrenstein.—p. 186.
Erythroblastosis Fetalis Associated with Rh-Positive Mothers. C. Chesner and J. A. Cicerrella.—p. 190.
Rupture of Liver and Spleen in Newborn Infant. P. Gruenwald.—p. 195.
Childhood Manifestations of Allergic Adults: Prelude to Allergy. A. B. Schwartz.—p. 202.
Preventive Orthopedics in Treatment of Poliomyelitis. J. F. Pohl.—p. 208.

Antibody Formation in Early Infancy.—According to Cooke and her associates the belief that there is a defect in the ability of young infants to produce specific antibodies has been widely held and has been the basis for the practice of deferring active immunization until later infancy. The authors made studies on 284 healthy infants, whose ages varied between 1 and 14 months, the majority being under 6 months of age. At the first visit, blood was drawn, tested for diphtheria and tetanus antitoxins, and a subcutaneous injection of combined diphtheria and tetanus toxoid given. A second injection of the same material was given two months later, and one month after this second injection a blood sample was again titered for diphtheria and tetanus antitoxin. It was found that the production of tetanus antitoxin is as good in the early months of life as later, and this finding denotes that the mechanism for the production of antibodies is well developed in young infants. With diphtheria antigen, the development of antitoxin is definitely defective in a considerable number during the first six months of life. This impairment of antibody formation is related to the presence of passive immunity in the resistant infants and appears specific for diphtheria. Recently, there has been some tendency to use a routine of diphtheria, pertussis and tetanus antigens by simultaneous injection. While such multiple antigens are as effective in immunization as those given individually, they would seem to be most useful when given to infants after six months of age. Since there exist definite advantages in immunizing against diphtheria later in infancy and against pertussis in the early months, the "timing" is bad for routine use of combined antigens. A course which appears to meet the requirements, and which has been in use in the Washington University Children's Clinic for the past year, is to give pertussis vaccine at the sixth, ninth and twelfth weeks, and combined diphtheria and tetanus toxoids in the seventh and ninth months.

Sickle Cell Anemia and Rheumatic Heart Disease.—Ohrenstein calls attention to the confusing resemblance between the symptoms of sickle cell anemia and those of rheumatic heart disease. It is often overlooked that anemia may cause heart disease, and it may be difficult to decide whether sickle cell anemia alone is present or whether there is an accompanying rheumatic heart lesion. The pathology files of the Cook County Hospital were searched to ascertain the incidence of sickle cell anemia concomitant with rheumatic heart disease. Since 1929, 53 autopsies have been performed on patients who gave positive evidence of sickle cell anemia. In 13 of these sickle cell anemia was the direct cause of death. Among the remaining 40 patients sickle cell anemia was an indirect cause of death. Three of these patients showed evidence of rheumatic heart disease, and the primary anatomic diagnosis in 2 of these was rheumatic heart disease. The ages of these 3 patients were 3, 7 and 22 years. The incidence of sickle cell anemia concomitant with rheumatic heart disease was 5.6 per cent.

Military Surgeon, Washington, D. C.

103:85-168 (Aug.) 1948. Partial Index

Red Cross Blood Program. G. B. Dowling.—p. 94.
Human Tolerance to High Linear Accelerations of Short Duration. W. H. Ames.—p. 96.
Problems of Human Engineering in Regard to Sudden Decelerative Forces on Man. J. P. Stapp.—p. 99.
Deep-Sea Diving with Synthetic Gas Mixtures. A. Zetterström.—p. 104.
*Prevention of Decompression Sickness and Nitrogen Narcosis by Use of Hydrogen as Substitute for Nitrogen (Arne Zetterström Method for Deep-Sea Diving). H. Bjurstedt and G. Severin.—p. 107.
Group Psychotherapy with Soldiers and Veterans. W. C. Hulse.—p. 116.
Observations on Diphtheria and Diphtheria Bacilli in 5th Army Troops in Italian Campaign. A. H. Stock, I. Eisenstadt, G. W. Triplett and S. Ashe.—p. 121.
Corrective Physical Rehabilitation—Effective Approach. J. L. Rudd, R. J. Margolin and C. L. Rose.—p. 125.
Improvement of Leg Prostheses. U. K. Henschke and H. A. Mauch.—p. 135.

Prevention of Decompression Sickness by the Arne Zetterström Method for Deep-Sea Diving.—Bjurstedt and Severin describe the Zetterström hydrogen deep diving method as developed and practiced in the Royal Swedish Navy. The theoretic properties of hydrogen as a substitute for the nitrogen of the air for diving purposes are discussed. Comparisons are made between nitrogen, hydrogen, helium and other gases with respect to gas uptake and elimination, narcotic effect and inhalational resistance. The authors also discuss the basis for the calculation of hydrogen half-times and decompression tables and curves and report practical diving experiments in the open sea with the hydrogen deep diving method.

New England Journal of Medicine, Boston

239:245-282 (Aug. 12) 1948

*Diagnostic and Therapeutic Problems in Diverticulitis. C. P. LeRoyer Jr. and B. V. White.—p. 245.
Relapsing Kala-Azar: Report of Case with Cure Effected by Stilbamidine. P. R. Wilner and T. A. Haedicke.—p. 250.
Cesarean Section at Boston City Hospital, 1936-1946. D. J. McSweeney and A. J. Hassett.—p. 254.
Hospital Administration as Career. E. M. Bluestone.—p. 258.
Chemotherapy of Neoplastic Disease: II. Trends in Experimental Cancer Therapy. D. A. Karnofsky.—p. 260.
Subacute Glomerulonephritis. Severe Pulmonary Edema.—p. 271.
Carcinoma of Gall Bladder, with Massive Involvement of Liver and Metastases to Adrenal Glands.—p. 274.

Diverticulitis.—LeRoyer and White report on 200 cases of diverticulitis seen at the Hartford Hospital during the years 1927 to 1946. The diagnosis was made by the clinical picture in addition to the roentgen findings in 161 cases, at operation in 32, by the clinical picture alone in 5 and at necropsy in 2. The relative incidence of the leading symptoms and signs was essentially similar to that generally reported. A notable exception was the occurrence of pain in the lower part of the back as a prominent symptom in 20.5 per cent of the cases. The presence of melena was noted in 16.5 per cent of the cases. The frequency of bleeding from the rectum is somewhat disconcerting, because it detracts from the significance of blood in the rectosigmoid as an indication of polyps or other neoplastic lesions and complicates the differential diagnosis. Diagnostic confusion occurred most frequently in cases presenting signs suggestive of acute appendicitis and in those in which masses in the lower part of the abdomen or pelvis could not be differentiated from carcinoma of the bowel or from genitourinary lesions. Complications occurred in 50 cases. These included 7 of obstruction secondary to ligneous induration of the affected sigmoid and 43 perforations. Thirty-two of the latter led to local abscesses, 6 to fistulas, 4 to mechanical obstruction and 1 to generalized peritonitis.

New Jersey Medical Society Journal, Trenton

45:377-426 (Aug.) 1948

Cancer and Precancerous Lesions of Skin. E. Kusnitzky.—p. 379.
Prevention of Treatment Complications in Syphilis with New Parenteral Multi-Vitamin Therapy: Preliminary Report. P. R. Kline and J. J. Colavita.—p. 385.
Bichloride of Mercury Poisoning Treated with Sodium Formaldehyde Sulfoxylate: Report of Case. J. Sarokhan.—p. 387.
Hay Fever: Panel Discussion. C. G. Weston and others.—p. 389.
Pyribenzamine Fever: Report of Case. S. J. Fanburg.—p. 392.
Compulsory Treatment of Narcotic Addict. G. H. Williams.—p. 393.
Carcinoma of Gall Bladder. S. M. Gilbert.—p. 395.
*Dangers in Use of Penicillin in Diphtheria and other Upper Respiratory Infections. W. Stein.—p. 398.
Roentgen Evaluation of Abdominal Pathology. R. Pomeranz.—p. 402.
Operative Aspects of Low Back Pain. H. Briggs.—p. 404.

Dangers in Use of Penicillin in Diphtheria.—Stein points out that diphtheria has become more prevalent during the war and immediate postwar period. An infection of the upper respiratory tract caused by the diphtheria bacillus could be hastily classified as "ordinary" pharyngitis. Such a diagnostic error, apart from the failure to use antitoxin, may lead to the use of penicillin, thus masking the diagnosis and giving the toxin a chance to spread. The author reports a case which illustrates the tragedy of not making a correct diagnosis of diphtheria. This patient was treated with penicillin and was discharged on the ninth day. Later he had to be readmitted, and he died on the twenty-seventh day. Necropsy revealed diphtheritic myocarditis. The author reports 2 other cases which illustrate the possibility of confusion between follicular tonsillitis and faucial diphtheria. A fourth case reported was one of nasal diphtheria. The author stresses that diphtheria should always be kept in mind in the presence of nasopharyngeal and tonsillar infection. Penicillin should not be used in such cases until the diagnosis is certain. Smears and cultures should be taken first and antitoxin should be given if diphtheria can be suspected, for penicillin cannot replace diphtheria antitoxin in the treatment of acute diphtheria. It can be of value in the treatment of the chronic diphtheria carrier state.

New York State Journal of Medicine, New York

48:1647-1758 (Aug. 1) 1948

Incidence of Pulmonary Tuberculous "Spreads" Following Thoracic Surgery and Anesthesia. W. M. Parke Jr., E. R. Loftus and H. F. Bishop.—p. 1685.
Intrathecal Use of Pitressin for Prolongation of Spinal Anesthesia. O. H. Stover.—p. 1689.
*Intravenous Procaine in Management of Injured Hand. D. J. Graubard, M. H. Waldman and M. C. Peterman.—p. 1693.
Intravenous Anesthesia. P. W. Searles and Rose M. Lenahan.—p. 1699.
Pulmonary Pathology as Related to Infant Resuscitation. W. Schwab, H. D. Eastman and B. Enten.—p. 1703.
Esophageal Intubation for Repair of Pharyngo-Esophageal Diverticulum. R. N. Terry.—p. 1709.
Studies on Pharmacologic Properties of Procaine and Di-Ethyl-Amino-Ethanol. E. M. Papper, B. B. Brodie, F. A. Lief and E. A. Rovenstine.—p. 1711.
History of Intercostal Muscular Paralysis as Phenomenon of Anesthesia. G. E. Burford.—p. 1715.
*Treatment of Cutaneous Anthrax with Penicillin. J. R. Griffin, R. H. Shanahan and C. E. DeAngelis.—p. 1718.
Elusive Mental Cases. B. Liber.—p. 1722.
Hypertension: Manifestation of Hypertensive Vascular Disease. G. A. Perera.—p. 1734.
Some Contributions of Physical Medicine in Poliomyelitis. A. L. Watkins.—p. 1739.
Surgical Treatment of Advanced Carcinoma of Cervix. A. Brunschwig.—p. 1733.

Intravenous Injections of Procaine for Injured Hands.—Graubard and his co-workers treated 28 patients with trauma of the fingers, the hand or those contiguous structures which produced hand symptoms, with eighty-five infusions of 4 mg. procaine hydrochloride per kilogram of body weight to be given in twenty minutes. One gram of vitamin C was added to 1,000 cc. of isotonic solution of sodium chloride, containing 1 Gm. of procaine hydrochloride. Twenty-one patients had reflex sympathetic dystrophy, 2 had phantom limbs, 2 had stiffness of the hand after a fracture, 2 had contusions, abrasions and lacerations and 1 had a "trigger" finger. Relief of pain, early restoration of function and early rehabilitation were achieved by the intravenous use of procaine in the treatment of 27 of these patients. When procaine is administered intravenously it reaches the dysfunctioning capillary bed and anesthetizes the irritated nerve endings. The resulting relief of pain is usually accompanied by increased mobility and improved circulation. Procaine given intravenously will not overcome the pain initiated and maintained by a mechanical factor; three infusions given during a period of two weeks produced no change in the condition of the patient with "trigger" finger.

Penicillin in Cutaneous Anthrax.—Griffin and his coworkers treated with penicillin 17 employees in a carpet factory, 16 men and 1 woman between the ages of 25 and 69 years, who had cutaneous anthrax. The lesions were chiefly on the exposed parts of the body and on the right side. The average number of hospital days was twelve, with the shortest five and the longest thirty-three. In general, each patient received from 100,000 to 300,000 units of penicillin every three hours intramuscularly, with a total average of 12,882,940 units during the hospital course. All persons with lesions on face and head received sulfadiazine in addition to penicillin. In 1 case antianthrax serum was also used. No ill effects were noted. All patients recovered. The suspicion of anthrax, the promptness of reporting to the physician and the immediate institution of treatment were the three factors which made a malignant disease a rather benign innocuous one with a relatively uneventful course in the hospital.

Northwest Medicine, Seattle

47:549-615 (Aug.) 1948

General Formulation of Diagnosis of Heart Disease. C. S. Burwell.—p. 565.
Coronary Heart Disease in 1947. P. D. White.—p. 567.
Role of Electrocardiogram in Diagnosis of Coronary Artery Diseases. S. F. Aronson.—p. 571.
Drugs Useful in Treatment of Coronary Disease. R. C. Manchester.—p. 573.
Diagnosis of Angina Pectoris. C. E. Watts.—p. 576.
Operation for Relief of Pain in Angina Pectoris. R. H. Hoff and J. T. Robson.—p. 578.
Enterococcal Endocarditis. F. P. Mathews.—p. 581.
Penicillin (161,250,000 units) in Treatment of Subacute Bacterial Endocarditis. F. C. Mauney, H. R. Rich and J. B. Daily.—p. 582.
Carotid Sinus Syndrome. R. I. Crane and F. C. Mauney.—p. 585.

Oklahoma State Medical Assn. Jour., Oklahoma City

41:257-318 (July) 1948

Epidemiology and Treatment of Poliomyelitis. F. H. Top.—p. 259.
Relationship of Private Practitioner to Health Program. W. A. Loy and G. McDonald.—p. 265.
Public Health in Oklahoma. G. F. Mathews.—p. 268.
Internal Medicine and Family Physician. H. A. Christian.—p. 273.
Veterans Medical Care Plan. L. Sadler.—p. 275.
Report on Pre-Payment Plans for Medical and Hospital Care. C. Rodgers. —p. 278.

41:319-368 (Aug.) 1948

Gynecologic Aspects of Geriatrics. G. Rogers.—p. 321.
Hormone Therapy with Particular Reference to Menopause and Metrorrhagia. L. A. Gray.—p. 325.
Management of Ocular Diseases Commonly Seen in Children. A. W. McAlester.—p. 331.
Cervical Dysteria? T. C. Points.—p. 333.

Review of Gastroenterology, New York

15:657-738 (Sept.) 1948

*Anorectal Divulsion Versus Pectenotomy: Clinical, Histopathological and Surgical Study of Pectenosis in Anorectal Disease. M. G. Spiesman. —p. 667.
Digestive Tract Hemorrhage of Undetermined Origin: Clinical and Pathological Observations. I. R. Jankelson and L. R. Milner.—p. 692.
*Clinical and Gastroscopic Observations on Prolapse of Gastric Mucosa. H. F. Van Noate, W. T. Arnold and E. D. Palmer.—p. 696.
Study of Digestive Capacity of Stomach by Means of Physicochemical Methods (Part II). S. S. Cytronberg, Angel L. A. Del Castillo and A. De Lachica.—p. 702.

Anorectal Divulsion Versus Pectenotomy.—Spiesman examined microscopically the anorecta of 14 adults, of 5 newborn infants, of 3 dogs and 2 rabbits, and 16 stained sections of removed pecten bands. Comparison of the normal and pathologic pecten areas proved that true pecten bands are not found in normal recta, but that pectenosis is a pathologic entity caused by chronic passive congestion and inflammation, as first suggested by Miles and Abel. Pecten bands are fibromuscular bands consisting of larger amounts of fibrous connective tissue intermingled with smaller amounts of smooth muscle fibers. These latter fibers are some of the terminal branches of the longitudinal muscle fibers of the rectal wall terminating in the pecten area, or possibly extensions of the muscularis mucosae of the rectum, or both. Pecten bands were found mainly in the pecten area but frequently extended above and below the pecten area. The pecten bands varied in thickness from 1.5 mm. to over 5 mm. The duration of the disease determines the existence and amount of infiltration fibrosis or hyalinization in the subpecten area. The cutting of the sphincter muscles is not necessary or advisable. Pectenotomy—i. e., incision of the pecten band—results in normal relaxation of these muscles. Anorectal divulsion is unsurgical, traumatic and unnecessary. Pectenotomy is the surgically correct procedure replacing the objectionable practice of divulsion. Clinically, pectenosis is commonly found in patients suffering from cryptitis, papillitis, anal spasm, fissure in ano, pruritus ani and hemorrhoids. Pectenotomy offers a new surgical approach to the treatment of common anorectal conditions.

Prolapse of Gastric Mucosa.—Van Noate and his co-workers report 7 patients, 6 men and 1 woman between the ages of 23 and 60 years, with complaints of the upper part of the gastrointestinal tract, who were observed to have only prolapse of the gastric mucosa as the explanation for their symptoms. Intermittent epigastric pain was the presenting complaint of all but 1 patient, nausea and vomiting occurred in 5 and were associated with pain, bloating and epigastric fulness in 4. A variable filling defect in the pyloric portion of the duodenal bulb, with an "umbrella" or "mushroom" configuration, was the most constant roentgenologic observation in this series. Serial gastroscopic studies failed to demonstrate disease of the antral mucosa in any patient. Other diseases of the antrum were therefore satisfactorily excluded. Chronic gastritis was not an etiologic factor. No secondary changes in the mucosa resulted from the prolapse. In each patient a simple medical regimen adequately controlled the symptoms and in none did the clinical, roentgen or gastroscopic observations indicate the necessity for surgical treatment. Enforced rest may well have been the most important therapeutic influence.

Southern Surgeon, Atlanta, Ga.

14:477-610 (Aug.) 1948. Partial Index

Venous Thrombosis. A. Ochsner.—p. 477.
Strictures of Esophagus. M. G. Lynch.—p. 502.
Fatalities from Spinal Anesthesia. J. Adriani.—p. 506.
Acute Obstruction of Small Bowel. O. C. Cassegrain.—p. 519.
*Volvulus of Colon: Study of 24 Cases. M. L. Michel and E. L. McCafferty.—p. 525.
Regional Enteritis. F. L. Loria.—p. 542.
Surgical Management of the Tubal Factor in Sterility. B. B. Weinstein. —p. 556.
Surgical Treatment of Malignant and Benign Obstructive Lesions of the Esophagus. M. E. DeBakey and A. Ochsner.—p. 562.
Significance of Bronchoscopy in Bronchiogenic Carcinoma. C. H. Steele. —p. 576.
Hemostasis of Parturient Canal. J. P. Michaels and J. S. Herring. —p. 583.
*Bronchiogenic Carcinoma. A. Ochsner, M. E. DeBakey and I. M. Richman.—p. 595.

Volvulus of Colon.—According to Michel and McCafferty volvulus of the colon is a relatively infrequent form of intestinal obstruction which carries a high mortality. In a series of 119 cases of acute obstruction of the large bowel (exclusive of the rectum) observed by the authors at Charity Hospital of Louisiana at New Orleans and at Touro Infirmary, there were 24 cases of volvulus. The age range in this series was 13 to 84 years, but volvulus is predominantly a disease of middle and late life, and it is rather unusual to find, as in this series, patients of 13, 17 and even 25 and 28 years of age. The 3 patients with volvulus of the cecum were 17, 28 and 40 years of age, respectively, which makes their average age 28.3 years, as compared with an average of 55 years for the 21 patients with volvulus of the sigmoid colon. The advanced age of the majority of patients largely explains the unfavorable prognosis. Two of the 6 patients who died were 78 years of age, 1 was 79 and 2 were 84. The sixth patient, aged 28, was moribund when hospitalized. The diagnosis of volvulus can be made on the basis of a history of (1) sudden acute abdominal pain, sometimes associated with a previous history of similar, less acute attacks or of milder symptoms; (2) nausea and vomiting; (3) constipation; (4) distention, sometimes associated with circulatory collapse; (5) tenderness, and (6) absence of fever early in the illness. The treatment of all cases of volvulus of the colon by the same method can lead only to disaster. Each case must be individualized with respect to the location of the volvulus, the degree of circulatory change in the wall of the affected bowel and the status of the patient. Treatment may be proctosigmoidoscopic intubation or operative intervention, which may range from simple detorsion to resection. Volvulus of the transverse colon and cecum must be treated surgically. Conservative measures have no place in the treatment of volvulus of the large bowel. Deaths from shock and peritonitis in volvulus of the colon emphasize the importance of prompt diagnosis and treatment, before irreversible circulatory changes have occurred.

Bronchiogenic Carcinoma.—Ochsner and his associates review observations on 548 cases of bronchiogenic carcinoma, of which 194 were considered inoperable when first seen. Of the 354 patients with cancer considered operable, 47 refused operation. Of the 307 cases in which an exploration was done, 112 were found to be nonresectable and in 195 a pneumonectomy was done. In 138 the operation was considered as a palliative procedure because of the extension, either grossly or microscopically, to other structures; in only 57 was the procedure considered curative. The hospital mortality rate has progressively decreased with experience. Whereas before 1940 it was 65.5 per cent, in 1948 it is 11.1 per cent. Even though in almost three fourths of the 195 cases the operation was done at a time when the lesion had extended beyond the originating lung, the survival rate is considerable. Over half of the patients are alive at the end of six months. In the group in which a curative resection was done, 14.5 per cent are alive at the end of five years, and 12.5 per cent of those in whom a palliative resection was done survived the operation five years. In none of the cases in which resection was not done did the patient survive as long as three years, although all patients were treated by the accepted nonsurgical therapeutic measures, such as therapy with high voltage roentgen rays, nitrogen mustard and antireticular cytotoxic serum.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

2:187-236 (July 24) 1948

Some Aspects of Treatment of Skin Diseases. J. T. Ingram.—p. 187.
Globin Insulin: Clinical Study. G. M. Wauchope.—p. 191.
Renal Complications in Diabetes Mellitus with Special Reference to Kimmelstiel-Wilson Lesion. W. R. Gauld, A. L. Stalker and A. Lyall. —p. 194.
*Diabetic Coma. R. H. Micks.—p. 200.
*Treatment of Chronic Varicose Ulcers by Lumbar Sympathectomy. J. Borrie and E. V. Barling.—p. 203.

Diabetic Coma.—Micks advocates the treatment of diabetic coma which was outlined by Root of Boston and his colleagues. The essential point of this treatment is the administration of large doses of insulin as early as possible. The longer the delay in administering an adequate dose, the greater is the dose required to cure the patient. It is better to err on the side of giving larger doses than necessary, than not giving enough. Hypoglycemia is a minor complication and easy to deal with. Gastric aspiration must be carried out in every case of diabetic coma, and nothing must be given by mouth during the critical first few hours. Intravenous administration of isotonic sodium chloride solution is needed in the cases of severe disease, sometimes in large quantities. The syndrome of potassium depletion, although rare, should be kept in mind. Dextrose must not be given by any route until clinical recovery has been achieved, but after this it may safely be given to prevent hypoglycemic attacks.

Lumbar Sympathectomy in Varicose Ulcers.—Borrie and Barling show that varicose ulcers may fail to heal even after the entire gamut of medical and surgical treatments. Four such patients, with ulcers present from fifteen to thirty-nine years, were found to have cold blue limbs which responded by cutaneous vasodilatation to lumbar paravertebral block. After lumbar sympathectomy these ulcers healed within three weeks. In 3 cases they have remained healed. When they treated their first patient by lumbar sympathectomy, the authors were not aware that this treatment had been used for varicose ulcers before, but later they found that it had been used by others, particularly in South America. Sympathectomy has also been condemned, because recurrences resulted. The ulcers reported here have remained healed throughout two winters. The value of lumbar sympathectomy in providing an adequate circulation to assist healing is thus demonstrated. The authors consider it advisable to resort to sympathectomy before skin grafting, because by improving the peripheral circulation a better bed is provided for the graft. They also stress the importance of continuing to wear an elastic stocking after treatment to protect the skin from trauma from without and edema from within.

Glasgow Medical Journal

29:235-266 (July) 1948

*Streptomycin in Tuberculous Meningitis in Childhood: Pathologic Findings in Six Fatal Cases. G. L. Montgomery.—p. 235.
*Stilbestrol in Late Malignant Disease of Breast. I. P. F. Rae.—p. 248.
Hereditary Hemorrhagic Telangiectasia: with Report of Case. T. McEwan. —p. 255.

Streptomycin in Tuberculous Meningitis.—Montgomery records the pathologic and the microscopic observations on 6 children who died while under treatment with streptomycin for tuberculous meningitis. The most remarkable feature in this group of cases is the persistence of progressive meningeal lesions due to streptomycin-sensitive organisms, while in general the systemic foci of tuberculosis showed evidence of regression. It would appear that this paradoxic situation must be related to environment rather than to the micro-organism itself, that at a certain stage the local tissue reaction prevents the direct contact between the chemotherapeutic agent and the infecting organism. Accordingly, the pathology of fatal cases adds weight to the plea for earlier diagnosis so that treatment may begin before irreversible tissue changes occur.

Diethylstilbestrol in Cancer of Breast.—Rae says that in earlier British reports on the use of diethylstilbestrol in mammary cancer the daily dose averaged just under 10 mg. per day, usually in three divided doses, but later the conclusion was reached that 15 mg. per day was the optimum dose. In most of the 12 cases reviewed in this paper, 15 mg. per day was given, but in some diethylstilbestrol was replaced by dienestrol, which produces similar effects with about one third of the dose and seems slightly less toxic. Five of the patients had received no treatment before the hormone therapy was started, the others had been subjected to mastectomy or/and irradiation with radium, roentgen rays or both. Only 4 of the 12 patients failed to show any response to the estrogen therapy, and 3 of these were moribund when this treatment was started. One patient has so far survived more than two years. This and 1 other patient who survived more than one year were both over 70 and had a single ulcerated growth. This is in agreement with the published findings that ulcerative types of neoplasm in aged patients give the best results. It is, however, also in patients with a single growth that surgical treatment has the best results, if seen at a reasonably early stage. Estrogen therapy may have its place in patients frail and over 70, surgical treatment being undertaken if no response occurs in two to three weeks and if the growth is single and with no or small axillary metastases.

Journal of Laryngology and Otology, London

62:435-486 (July) 1948

Surgery of Aural Suppuration After Radical Mastoidectomy. J. A. Harpman.—p. 435.
New Method of Transverse Pharyngotomy. A. Réthi.—p. 440.
Treatment of Inflammations of Inner Ear by Sulfa-Drugs. A. A. J. Van Egmond and L. B. W. Jongkees.—p. 447.

Journal of Tropical Medicine and Hygiene, London

51:133-154 (July) 1948

Investigation into Causes of Severe Anemia in Fiji. B. T. Barnes. —p. 133.
Millet Beer and Peanuts as Protective Foods in Africans. N. L. Corbitt, H. Creditor and G. E. S. Stewart.—p. 140.
*Cholera Vaccines. M. A. Gohar.—p. 144.

Cholera Vaccines.—Gohar made animal experiments to compare the protective value of the following types of cholera vaccines: (1) a heat-killed phenol-preserved vaccine; (2) a formaldehyde-killed phenol-preserved vaccine; (3) a soluble extract prepared by adding to a suspension containing 8 billion organisms per cubic centimeter an equal quantity of normal sodium hydroxide and incubating at 37° C. until the organisms are dissolved and the suspension becomes clear. This is subsequently neutralized until it is just alkaline; (4) a toxoid prepared by treating a toxin with formaldehyde solution and then incubating for twenty days, and (5) a mixture containing equal parts of toxoid and vaccine. It was found that this last preparation gives the best results.

Lancet, London

2:129-168 (July 24) 1948

American Teaching Hospital. E. Davis.—p. 129.
*Sulphetrone: Therapeutics and Toxicology. G. Brownlee.—p. 131.
*Chemotherapy of Pulmonary Tuberculosis with Sulphetrone. T. Anderson and S. J. Strachan.—p. 135.
Obstetric Evaluation of Pubic Arch: Clinical Method. W. I. C. Morris. —p. 139.
*Laryngeal Swab in Early and Convalescent Cases of Pulmonary Tuberculosis. G. B. Forbes, B. J. D. Smith, J. V. Hurford and V. H. Springett.—p. 141.
Cysticercosis Cerebri Mistaken for Cerebral Syphilis: Report of Case. A. A. Williams.—p. 144.
Phlyctenular Kerato-Conjunctivitis Treated with Penicillin. R. W. Stephenson.—p. 144.

Sulphetrone.—Brownlee discusses the therapeutic and toxicologic aspects of sulphetrone (4:4'-bis[gamma-phenyl-N-propylamino diphenylsulfone-tetra sodium sulfonate]). Previously he had described its structure, pharmacology and suppressive effect on progressive experimental tuberculosis in guinea pigs. The acute toxicity of sulphetrone in experiments on animals is slight. No acute toxic effects have been observed in man. The chronic hematotoxic effects in rabbits and in man include hemolytic anemia, anemia of iron lack and anemia of nutritional origin. Sulphetrone has a goitrogenic effect similar to that of sulfonamide drugs, but this is only slight in experiments on animals and has not been observed in patients receiving the drug. Sulphetrone given by mouth or parenterally raises the

alkali reserve of the plasma of rabbit and dog. The probable mechanism is discussed. Given over a long period it brings about some tolerance. It is thought that the period of adjustment seen during the first three weeks of sulphetrone therapy is associated with adjustments of alkali reserve. The minor discomforts encountered during this period are relieved by bicarbonate, but not so well by other alkalis. Though very soluble in water, sulphetrone is slowly absorbed from the intestinal tract—most from the small intestine, little from the large. Sulphetrone is cleared by the kidney quickly, and fluid must be limited to maintain blood sulphetrone concentrations. There is also a substantial excretion into the bile and to a lesser extent into the ileum. The drug is not conjugated, so that there is no danger of crystalluria. Sulphetrone penetrates all tissues, except brain, rapidly. It passes into the cerebrospinal fluid more slowly than do sulfonamide compounds.

Sulphetrone in Pulmonary Tuberculosis.—Anderson and Strachan review the results of a trial of sulphetrone in tuberculosis. The drug exerted no beneficial effect on the course of tuberculous meningitis, miliary disease or bronchopneumonia. Meningitis followed the usual downhill progression to death in three or four weeks in all 7 cases. A table listing the results obtained in all the 100 cases with various forms of tuberculosis shows that 4 of 5 of patients with miliary tuberculosis and all 4 with bronchopneumonia died. All the 15 patients included in the second group showed extensive tuberculosis of both lungs. The prognosis from the beginning was bad, and only 1 of these showed benefit from the treatment. The third group comprised patients with pulmonary tuberculosis whose prognosis was initially hopeful, though in some of them the disease was fairly extensive. There were 36 patients in this group, and 23 of these showed improvement after a period of sulphetrone therapy. All received adequate and protracted treatment, and in 8 of the cases roentgenologic and bacteriologic examination supported a belief that the tuberculosis had been arrested. In 2 other patients the disease in one lung was arrested, and a thoracoplasty was performed on the opposite side; the patients are in excellent condition. The fourth group comprised 19 children (under 15 years of age). Of these 15 were discharged and seemed to have their tuberculosis arrested. Of 10 patients with tuberculous pleurisy who comprised the fifth group 6 were definitely and 2 slightly improved. The authors were impressed with the rapidity and completeness with which cure was obtained in 2 patients with cutaneous tuberculosis. Of 2 patients with genitourinary tuberculosis 1 was slightly and 1 definitely improved. These results give some basis for the belief that control of the disease by chemical means is possible.

The Laryngeal Swab in Pulmonary Tuberculosis.—In 100 inpatients and 101 outpatients with roentgenologic evidence of pulmonary tuberculosis but with microscopically negative or no sputum, Forbes and his co-workers made a search for tubercle bacilli by culture of fasting gastric contents and of laryngeal swabs. Gastric lavage gave slightly superior results for inpatients; there was no difference between the proportions of positive results obtained by the two methods in outpatients. Patients greatly prefer the laryngeal swab to gastric lavage. Laryngeal swabs can be taken as part of a routine examination without special attendance or preparation. The laboratory technic for laryngeal swabs is simpler and less time consuming than that for gastric lavage. It is not suggested that these methods should take the place of the cultural examination of expectorated sputum, which has been shown in a comparative series to be much superior to the laryngeal swab.

Medical Journal of Australia, Sydney

2:29-56 (July 10) 1948

Social Health and Psychiatric Service. A. Stoller.—p. 29.
*Human Botulism in Australia. D. F. Gray.—p. 37.

Botulism.—Gray says that two outbreaks of botulism occurred in widely separated places in Queensland in November and December 1942. Both were attributed to commercially canned beets. In assessing the possible future implications of these two outbreaks, it is perhaps as well to realize that Clostridium botulinum is a widely distributed normal saprophytic inhabitant of soil. Therefore, given suitable conditions, such as faulty or otherwise inadequate processing of commercially canned or home-canned, nonacid foodstuffs, in which heating is either inadequate or of insufficient duration to destroy all spores, or if contamination can occur after processing through undetected faults in cans, then further outbreaks are not impossible. Factors which might explain the comparative variety of botulism include among others the fact that few persons fail to realize the danger inherent in a can of food which has lost its vacuum, or of which the contents appear in any way abnormal. There are very few potentially dangerous foodstuffs, beets being a notable exception, which are not preheated before being served.

Acta Medica Scandinavica, Stockholm

120:507-602 (June 26) 1948

Hemorrhagic Thrombocythemia. J. E. Holst.—p. 507.
Technical Errors in Taking of Electrocardiograms and Consequent Misinterpretation. T. Mot.—p. 515.
*Variations in Serum Proteins in Liver Diseases with Special Reference to Diagnostic Significance. H. A. Salvesen and O. Lödöen.—p. 525.
Effect of Some Common Gastric Drugs on Motility of Stomach. P. Brunner and A. Bundul.—p. 559.
*Hypertensive Diencephalic Syndrome. F. S. R. van Buchem.—p. 575.
Cushing's Syndrome in 55 Year Old Man: Report of Case with Decreased Serum Protein Values and Pathologic Changes of Adrenal Cortical Cells. C. J. Bjerkelund and O. Torgerson.—p. 584.

Serum Proteins in Liver Disease.—Salvesen and Lödöen were interested for many years in ascertaining the diagnostic value of serum protein determinations in hepatic diseases. They found that in healthy persons the total protein varied between 6.11 and 7.62 Gm. (average 6.96) and the albumin-globulin ratios between 1.49 and 2.85 (average 1.97). Studies were made on 148 patients with various types of liver disease. In 24 cases of acute benign hepatitis the albumin-globulin ratios varied between 0.57 and 1.71; of 34 determinations 18 were below and 16 above 1. There was distinct hyperproteinemia in 4 cases. In hepatitis ending fatally or turning chronic (25 cases) the albumin-globulin ratios were always below 1 except in 2 cases during temporary improvement, when they rose to 1.16 and 1.07 respectively. Of 78 determinations 68 showed an albumin-globulin ratio below 0.80 with a lowest value of 0.12. In 10 of the 25 cases considerable hyperproteinemia was observed. In toxic hepatitis due to medication (5 cases) the albumin-globulin ratios were normal in 3 and below 1 in 2 of the cases, of which the last one was a case of acute yellow atrophy with an albumin-globulin ratio of 0.59. In 26 cases of cirrhosis the albumin-globulin ratios were all below 1. In a case of thrombophlebitic splenomegaly the albumin-globulin ratio fell to 0.74 during ten years of observation as cirrhosis developed. In gallstone occlusion with icterus (11 cases) the albumin-globulin ratios were above 1, except when cholangitic cirrhosis developed, when the ratio became less than 1. In gallstone without icterus (9 cases) the albumin-globulin ratios were normal or nearly so. In cancer hepatitis without jaundice (10 cases) the albumin-globulin ratios were above 1 except in a cachectic case with anasarca, in which it was 0.80. In carcinomatosis and sarcomatosis (7 cases) the albumin-globulin ratio was 0.91 in 1 out of 11 determinations; all the others were slightly reduced, but above 1. In 6 cases of liver enlargement of various causes the albumin-globulin ratios were normal or somewhat reduced, but all except one were above 1. In 7 cases of hemolytic jaundice the albumin-globulin ratios were high. The Takata reaction, which was positive in nearly all the cases of fatal or chronic hepatitis and cirrhosis, was not always related to the albumin-globulin ratio or the globulin content. The authors conclude that the determination of serum proteins in hepatic disease may be of considerable help to the diagnostician.

The Hypertensive Diencephalic Syndrome.—Van Buchem points out that Page, in 1935, described a hypertensive diencephalic syndrome which he observed especially in young or middle-aged women. It is characterized by labile hypertension and by the periodic appearance of red patches on the skin of the neck and chest. The extremities are cold and pale. In some cases fits of weeping occur without emotional cause. Tachycardia and accentuated peristalsis are observed. These phenomena become particularly severe under the influence of

excitement, but may also occur without it. A diagnosis of thyrotoxicosis is frequently made, because the thyroid is usually slightly enlarged and the basal metabolic rate often raised. Subtotal thyroidectomy gives no result. Page used the term diencephalic syndrome because the signs can be provoked by diffuse stimulation of the diencephalon in human beings. The author has examined a number of patients with this syndrome and presents histories of 10 of these. Tachycardia, increased basal metabolism, hypertension with normal renal function, usually a fine tremor of the fingers and frequently enlargement of the thyroid were the symptoms found in these patients. The patients show decided dermography and numerous red patches. With regard to the differentiation from thyrotoxicosis, the author observed a typical difference as regards the cholesterol content of the blood; this is generally lowered in thyrotoxicosis, whereas in these patients it was usually high. Since "prominal" (barbituric acid preparation) is known to have a sedative effect on the brain stem, the author gave his patients 200 mg. two or three times daily. This was followed by considerable improvement. The pulse rate dropped to normal, the basal metabolism approached the normal and a striking decrease in blood pressure occurred.

Hospital, Rio de Janeiro

38:835-970 (June) 1948. Partial Index

*Aerosol Penicillin in Respiratory Infections. - Araujo Cintra, A. Sanglovanni and S. Costa Bosch.—p. 855.

Aerosol Penicillin in Infections of the Respiratory Tract.—Cintra and his collaborators treated 88 patients with respiratory disease with inhalations of penicillin aerosol. The inhalations were practiced four times daily, each inhalation containing 100,000 units of penicillin. The fourth and last inhalation of the day was followed by a parenteral injection of 300,000 units of penicillin in wax and oil. Streptomycin was added to the treatment when gram-negative bacteria predominated in the sputum. A desensitization treatment was given in the course of penicillin aerosol therapy when the respiratory disease was of an allergic origin, and autovaccines in infectious and catarrhal asthmatic bronchitis. Following results are reported one and two years after discontinuation of treatment: In a group of 43 patients with bronchial asthma clinical cure was obtained in 8 cases, great improvement in 24 patients with periodic asthma, great and relative improvement, respectively, in 6 patients with acute asthma with frequent crises and great improvement in 5 cases of permanent grave asthma (status asthmaticus). The groups of patients with sinusitis and bronchitis consisted of 25 and 20 patients respectively. Clinical cure was obtained in 10 cases of bronchitis and in 5 cases of sinusitis, great improvement in 11 and 4 cases of bronchitis and sinusitis respectively and relative improvement in 6 and 7 cases of bronchitis and sinusitis respectively. The authors conclude that penicillin aerosol inhalation is indicated in the treatment of almost all respiratory infections, even after failure of parenteral administration of penicillin.

Medicina, Buenos Aires

8:93-186 (April) 1948. Partial Index

*Therapeutic Use of Nitrogen Mustard. M. R. Castex, A. Pavlovsky and J. Pandra.—p. 93.

Nitrogen Mustard. — Castex and his collaborators used methyl-bis (beta-chloroethyl) amine in the treatment of 7 patients with Hodgkin's disease, 1 patient with lymphosarcoma and 2 patients with chronic myeloid leukemia. The drug was given intravenously in doses of 5 and 8 mg. The injections were given every other day up to a total of four injections for each series. The number of series varied from one to three with intervals of from one to three months. Five of the 7 patients with Hodgkin's disease had been previously treated with roentgen rays. Two had received no previous treatment. Nitrogen mustard improved the patients with lymphogranuloma or leukemia. One of the patients with leukemia has been treated with only this drug for one year and three months. In the other case methane, roentgen therapy, nitrogen mustard and a folic acid preparation were used successively. The effect of nitrogen mustard is similar to that of roentgen rays but is less intense and is of shorter duration.

Revista Medica de Chile, Santiago

76:185-240 (April) 1948. Partial Index

*Intrapleural Penicillin in Therapy of Nontuberculous Acute Empyema. R. Valdivieso, G. Sepulveda and R. Ramirez.—p. 185.

*Penicillin in Treatment of Endocarditis Lenta. R. Armas Cruz, M. Bensán Santander and J. Vigouroux Bernéri.—p. 218.

Intrapleural Penicillin.—Valdivieso and collaborators report on intrapleural injections of penicillin in 20 adults and 10 children with nontuberculous acute empyema. In the majority of the cases empyema was secondary to acute disease of the lung. Diplococcus pneumoniae was the causal agent in the pleural pus in 14 cases; streptococcus and staphylococcus alone or combined in 6 cases, while in 9 cases the pleural pus was sterile. The usual intrapleural dose of penicillin varied from 40,000 to 100,000 units in concentration which varied from 500 to 5,000 units for each cubic centimeter. The average total dose for every patient was 450,000 units. The pleural pus proved to be sterile after the first and second injection in most of the cases and after the third injection in rare cases. Administration of penicillin continued after sterilization of the pleural pus. Penicillin by the systemic route was administered during the course of intrapleural treatment with penicillin when there were pulmonary or other complications. The time required for a definite cure was fifty-five days, with an average period of seventy-five days' stay in the hospital. Complications, if any, were insignificant and successfully controlled. In all cases but one permanent clinical and roentgenologic cure was obtained, which persists up to the present (several months after discontinuation of treatment). The only patient who did not obtain permanent cure was a man 80 years of age who discontinued treatment with a chronic cystic empyema and failed to report for further treatment.

Penicillin in Endocarditis Lenta.—Armas Cruz and collaborators report on penicillin therapy in 12 patients with subacute bacterial endocarditis. The drug was given by intramuscular injection in daily doses of 500,000 to 800,000 units for two consecutive months. Permanent cure was obtained in 7 patients, and persisted for observed periods of six months and two years in 6 patients and two months in 1 patient. Two patients died in the course of the treatment because of cardiac insufficiency, 2 had a reinfection and 1 discontinued the treatment at an early stage.

Semaine des Hôpitaux de Paris

24:1979-1998 (Aug. 14) 1948

*Treatment of 14 Patients with Leukemias by Simple Blood Transfusions; Favorable Results in 3 Lymphoid Leukemias of Splenic Type. Pasteur Vallery-Radot, J. Hamburger, P. Millies and others.—p. 1979.

Blood Transfusions in Leukemias. — Pasteur Vallery-Radot and his co-workers treated 14 patients, 7 with acute leukemia, 4 with myeloid leukemia and 3 with lymphoid leukemia, with transfusions of 300 to 500 cc. of fresh blood. The transfusions were repeated two to three times per week for several weeks. Six of the patients with acute leukemia and all 4 patients with myeloid leukemia were not benefited by this therapeutic method. The transfusions were well tolerated by the patients with acute leukemia, while bouts of fever with painful increase in the volume of the spleen occurred in some of the patients with myeloid leukemia. The treatment was effective in 3 male patients between the ages of 62 and 66 with lymphoid leukemia and in 1 patient with acute leukemia who presented an acute bout in the course of a lymphoid leukemia. The lymphoid leukemias were of the splenic type. The general condition and the hyperleukocytosis improved. This improvement continued for fourteen, eight and five months respectively in the cases of chronic lymphoid leukemia and for two months in the case of the acute bout of lymphoid leukemia. There was only a partial remission with the increased number of pathologic cells still remaining in the blood and bone marrow. The mechanism of action of the blood transfusions remains obscure, but the effect seems to be more than a purely substitutive one; although incomplete and transitory only, it may replace the roentgen treatment in certain cases of lymphoid leukemia and consequently perhaps delay the occurrence of resistance to irradiation.

Book Notices

A Manual of Practical Obstetrics. By O'Donel Browne, M.B., M.A.O., M.A., Master, Rotunda Hospital, Dublin. Second edition. Cloth. Price, 25s. Pp. 297, with 226 illustrations. Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, 1948.

Because of the war this edition appears twelve years after the first. Certain sections in the first edition were omitted in this one, but in their place greater attention has been devoted to antenatal care and diet. A short account is given of erythroblastosis fetalis, and reference is made to the more recent classification of pelvic types and deformities. The entire section on the concepts of puerperal fever and treatment has been brought up to date and changes have been made in the treatment of breech delivery.

Since this book was written chiefly for students and general practitioners, the aim of the author has been to be practical, and in this he has succeeded admirably. He has made no attempt to displace the more comprehensive textbooks on obstetrics because this small book contains only 251 pages of text. The book is divided into eleven chapters, the last of which deals with radiology and was written by C. L. McDonogh.

Too much space is devoted to incarceration of the retroflexed gravid uterus, which is a rare condition. The author still recommends that a douche apparatus be carried in an obstetric kit because he advocates an intrauterine douche for postpartum hemorrhage. Figure 40 shows a rectal examination being made with a finger covered by a rubber finger cot. It is almost impossible to make a rectal examination in this manner without having fecal matter touch the base of the finger. The author recommends that one leave the placenta for half an hour before expelling it, if no bleeding is present. Most American obstetricians express the placenta as soon as it has separated from the uterus. In the section on anesthesia, chloroform and ether are discussed at length. The author says that pudendal block "is troublesome, somewhat uncertain, unpleasant for the patient, and not devoid of danger." He does not recommend it. He also says "the technic of caudal anesthesia is complicated and difficult, the results variable and the dangers attending the method too great to permit its general use." He does not mention direct infiltration anesthesia at all.

For some cases of placenta praevia plugging the vagina and Braxton Hicks version are recommended, but few obstetricians in the United States employ either form of these treatments at the present time.

Since the author is Master of the Rotunda, it is natural that the Rotunda, conservative or Tweedy method of treating eclampsia should be described, but at present this method is greatly modified at the Rotunda.

In spite of the criticisms made, the book is definitely a practical book based on the author's extensive experience as a teacher and practicing obstetrician. It is well written and abundantly illustrated, and it covers all the essentials of obstetrics. It can be recommended highly.

Sterility and Impaired Fertility: Pathogenesis, Investigation and Treatment. By Cedric Lane-Roberts, C.V.O., M.S., F.R.C.S., Gynaecological Surgeon, Royal Northern Hospital, London, and others. Second edition. Cloth. Price, $8.00 Pp. 460, with 90 illustrations. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 49 E. 33rd St., New York 16, 1948.

This book has been prepared by five outstanding authorities in the field of infertility. It "is addressed not less to the general practitioner than to experts in the fields of gynecology, andrology, seminology and reproductive physiology." The chapters are not signed; hence the book gives the appearance of having been written by one person. The eight chapters are as follows: General Survey of the Problem, The Male Factor in Childless Marriage, The Constitution of Semen, Assay of Male Fertility, The Male Reproductive Mechanism and Its Disturbances, Treatment of Male Sterility, Sterility in the Female and Treatment of Female Sterility. In addition there is an extensive appendix in which there are descriptions of the examination of semen, estimation of pregnandiol, detection of chorionic hormone in pregnancy or suspected pregnancy, specific bacteriologic procedures in women, postcoital (Sims) and invasion tests, interpretation of waking temperature records, roentgen therapy and diathermy. At the end of the book is an extensive list of references.

The authors emphasize the value of waking temperature charts for the study of ovarian function, anovulatory cycles, inadequate luteinization, the diagnosis of impending abortion and the detection of early pregnancy. They believe that temperature records possibly are the simplest of all expedients for the discovery of an early gestation.

The importance of tubal insufflation in the diagnosis of sterility is emphasized, but the authors point out that findings which were formerly regarded as diagnostic of tubal stenosis or occlusion may indicate merely the presence of a temporary spastic condition that will resolve as soon as the patient's attention is effectively distracted; also that analysis of urinary hormones is now known in many cases to be a cumbersome means of eliciting information that can be more easily and effectively secured by far simpler diagnostic procedures.

Among the advances in therapy the authors lay stress on subclinical infections, particularly those localized in the cervix, as causes of subfertility and accordingly as determinants of the course of treatment. The use of sulfonamide compounds and penicillin has resulted in cure without the necessity for using the electric cautery or other surgical measures for many conditions which formerly proved intractable. The authors also discuss the use of roentgen stimulation, especially of the pituitary in cases of anovulation, and artificial insemination.

The book is definitely authoritative; it is well written, comprehensive and amply illustrated. It should be read by every one interested in the subject of sterility and impaired fertility.

Arthritis and Related Conditions. Edited by Theodore Franklin Bach, M.D., F.A.C.P., Associate in Medicine in the Graduate School of Medicine of the University of Pennsylvania, Philadelphia. Fabrikoid. Price, $6.50. Pp. 472, with 159 illustrations. F. A. Davis Co., 1914-16 Cherry St., Philadelphia 3, 1947.

The development of this book was interrupted by the untimely death of the original editor, Dr. R. Garfield Snyder. Bach states that Dr. Snyder's plan for the book, together with most of his chapter contributions, has been retained, as well as the chapters written by collaborators selected by him. It turns out to be just another book on arthritis which was poorly organized, carelessly written and sloppily edited. Much of the material is old, such as the chapter on focal infection, and much less interesting than it was ten years ago. There is practically nothing on antistreptolysins and agglutinins. The book abounds in generalizations about diagnosis and therapy without sufficient detailed information to be useful. The chapter on gold therapy consists largely of quotations from the literature, giving conflicting opinions without a clear summary and definite recommendation by the author. The table of dosage is given in the chapters on gold salt toxicity. The only tabulation of toxic effects is in a short paragraph quotation from the literature. Ankylosing spondylitis is almost completely ignored except for one short paragraph in the chapter on tuberculous arthritis under the heading of spondylitis rhizomelique, a term which outlived its usefulness decades ago. Despite the fact that confusion on terminology is one of the greatest handicaps to the understanding of joint disease by the general practitioner, the author here has given his own classification modified from those of the New York Rheumatism Association and the American Rheumatism Association. One can only hope that some day authorities on this subject will adhere to the classifications in the Standard Nomenclature of Disease.

The book is reasonably well illustrated. It is unfortunate that the authors chose five of the eight pictures in the chapter on the history of arthritis from A. B. Garrod, "Treatise on Rheumatism," London, 1890, and three from the chapter on Gout from A. E. Garrod, "On the Gout," London, 1859, without acknowledgment to the original authors in either case. The name of Arthur Krida, author of chapter XIII, on acute suppurative arthritis, was omitted from the list of contributors on the half title. Many readers probably would have been interested in some identifying information such as city of residence and institutional connection beyond the bare name of the contributors.

The book is recommended only to those readers who pride themselves on having a complete collection of titles on this subject.

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

INDICATIONS FOR CESAREAN SECTION

To the Editor:—A woman, aged 37, was referred to me for cesarean section. She was eight and one-half months pregnant, and according to recent roentgenograms the baby was in a left sacroanterior position with the presenting part not engaged. This was her seventh pregnancy. She has been married eight years and has living 3 healthy children who were all delivered after short labors. The other pregnancies ended spontaneously in miscarriages. A few years prior to marriage she had generalized peritonitis due to acute appendicitis with perforation. At that time she had a complication of severe phlebitis of the right leg, which since that time has been slightly larger than the left, and during her pregnancies she felt much more comfortable when wearing an elastic stocking. With all her pregnancies she has never had an acute flare-up of the phlebitis. During the present pregnancy the discomfort has been much worse, but she was still able to do her house work and take care of her children. Physical examination at this time reveals a pelvis normal to external measurements. There are no varicose veins or pitting edema. She wishes to have a cesarean section and sterilization at the same time. I told her that no section was indicated unless definite cephalopelvic disproportion was shown by roentgenogram at the onset of labor. Should her request have been granted?

M.D., Delaware.

ANSWER.—It was correct to refuse to do a cesarean section on this patient. It is unwise to perform a cesarean section simply to perform sterilization by ligation of the tubes. If there is an indication for a hysterectomy such as large fibromyomas there might be some justification, but this patient presumably has a normal uterus and has had no dystocia in previous labors. Furthermore, in view of the previous generalized peritonitis and the phlebitis there would have been a decidedly increased opportunity for serious trouble during and after the cesarean section. Incidentally, in the presence of normal babies, it is difficult to determine cephalopelvic disproportion in breech presentations. When a hydrocephalus is present, the enlarged size of the head is obvious, but in many roentgenograms of breech presentations, the head appears larger than it really is.

TETANUS REIMMUNIZATION

To the Editor:—Many ex-service men are seen for industrial injuries which require tetanus toxoid or antitoxin. Five years since discharge has been arbitrarily selected as a dividing line for the use of stimulating toxoid or passively immunizing antitoxin. (1) How long will a routine series plus one booster at one year's interval give immunity? (2) How frequently should "booster shots" be given to maintain this immunity? (3) If a man has received no stimulating dose of toxoid since his original series, at how many years' interval can a satisfactory immunologic response be expected from a stimulating dose? (4) To reimmunize a person who has had no toxoid for several years, is a complete series necessary or will one dose raise his titer satisfactorily? (5) What is an acceptable policy to be followed in the use of toxoid or antitoxin in ex-service men?

M.D., West Virginia.

ANSWER.—1. Accurate antitoxin estimations relative to the immunity conferred by a basic immunization with tetanus toxoid followed by a recall (booster) dose at the end of one year are not available. The experiences in the United States Army indicate that adequate response to a booster dose of toxoid was observed for at least three years after the basic immunization and two years after the routine recall dose. It is not unlikely that in some persons protection continues for considerably longer periods. The blood serum of only 4 of 42 subjects who had not received toxoid for from two to five years contained antitoxin in a concentration generally considered inadequate for protection.

2. While the majority of persons even at the end of five years after a basic immunization and one recall dose may have antitoxin concentrations adequate for protection, it is a sound policy to administer an emergency stimulating dose of 1.0 cc. (10 Lf.) fluid tetanus toxoid whenever an injury makes the danger of tetanus a possibility. There is good reason to believe that an adequate response occurs within the usual incubation period for tetanus.

3. According to Wishart and Jackson (*Canad. J. Pub. Health* 39:181-186 [May] 1948), 55 young adults who had been previously immunized with tetanus toxoid during the war all responded to a recall dose of 1.0 cc. of tetanus toxoid. In another study by McBryde and Poston, dealing with children (*J. of Pediat.* 28:692-696, 1946), those who received a small amount of tetanus toxoid subcutaneously five years after the original immunization showed a decided increase in serum antitoxin content. Thus, it is proved that for at least five years, probably longer, the immunologic response to a 1 cc. stimulating dose will be fully adequate.

4. If a person has had no toxoid for years a 1 cc. (10 Lf.) dose of fluid toxoid is probably adequate to recall the antitoxin level in the blood to a protective concentration of from 0.01 to 0.2 unit per cubic centimeter of serum.

5. Unless the ex-service man has retained a record of the immunizations administered to him while he was in service the proper procedure to be followed if he sustains wounds or injuries which may lead to tetanus may well be difficult to determine. "In general it is a reasonably safe procedure to administer [fluid] toxoid rather than antitoxin prophylactically if the individual concerned states that he was in the service for at least a year subsequent to Pearl Harbor, and that he received all of the routine immunizations administered in his organization. Such military experience would almost certainly indicate that he had received at least the basic tetanus immunization; hence, he could be expected to respond satisfactorily to a stimulating dose of toxoid" (Long, A. P., and Sartwell, P. E., *Bull. U. S. Army M. Dept.*, 1947, vol. 7, p. 384). When no adequate record of previous active immunization is available, antitoxin should be given prophylactically. Experience has taught that in civilian practice and in the presence of badly contaminated wounds the dose should be increased to 4,500 units given in three doses of 1,500 units over a period of six days.

ALUMINUM DUST IN SILICOSIS

To the Editor:—A male patient, aged 42, has slowly progressive pulmonary fibrosis as a result of exposure to silica dust at the age of 19. The present symptoms are dyspnea on exertion and nonproductive cough. Physical examination showed no cardiac involvement. There were numerous sibilant rales in both lung fields. The laboratory findings revealed a normal blood count, a normal electrocardiogram and a vital capacity of 68 per cent of normal. The roentgenogram of the chest revealed a large calcified node in the right hilar region and an increase of markings in the lung fields which I interpreted to be pulmonary fibrosis. Kindly advise treatment, especially with reference to aluminum. Is there any simplified office procedure for this method of treatment?

M.D., Texas.

ANSWER.—If your patient, now 42, has not been exposed to dangerous concentrations of silica dust since he was 19 years old, it is most unlikely that he has slowly progressive pulmonary fibrosis as a result of exposure so long ago. After both experimental and clinical studies, Gardner stated that one who has silicosis and is removed from the dust will have fibrosis develop progressively until all of the particles are encapsulated in nodules. Old nodules will not continue to enlarge or new ones form for an indefinite period. Hayhurst said that the pulmonary effects of silica have about spent themselves by the end of two years after the last work exposure and thereafter, unless the affliction is complicated by infection or emphysema, it remains practically stationary. Sander reported observations on 299 cases of silicosis selected from 3,377 foundry workers. Six years of observation prior to 1939 brought to light no case of visible progression of the silicotic fibrosis. He expressed the opinion that this is due to the fact that when the condition was discovered, although the workmen continued in the foundry, measures were instituted which markedly reduced the concentration of silica dust in the air which they breathed. He concluded that it is safe to keep those with uncomplicated silicosis at their regular work under the controlled conditions of minimal dust exposure and adequate respiratory protection, as well as under the medical control of periodic examination and absence of possibilities of contracting tuberculosis at work. Continued observation on the same persons has not changed Sander's opinion.

The large calcified node in the right hilar region is not adequate to make a diagnosis of silicosis. Such depositions of calcium are more often due to infections with tubercle bacilli or fungi, such as Histoplasma capsulatum and Coccidioides immitis. The increased markings in the lung fields may also be due to any one of a number of conditions other than silicosis. In fact, if definite nodulation is not in evidence, the condition is probably not due to silica dust.

There is no accepted treatment for well established silicosis. Denny and others have shown that aluminum dust in a concentration of about 1 per cent of the total dust inhaled affords some protection against the development of silicosis in animals. Gardner conducted experiments with animals which showed that aluminum and aluminum hydrate definitely inhibit the fibrous reaction of tissue to quartz. Moreover, they prevent progression of silicotic lesions already established and actually cause

retrogression in immature tissue responses. Some evidence has accrued to indicate that aluminum dust serves as a prophylactic among persons exposed to silica dust. This is probably because the silica particles become covered with an insoluble and impermeable coating which is gelatinous, hydrated alumina. Therefore, prophylactic treatment has been installed in many places where workmen inhale a high concentration of silica dust. Not enough work has been done to justify ultimate conclusions concerning the efficacy of aluminum dust in prophylaxis.

Vrooman stated: "It will be some years before . . . its full value in humans [can be assessed.] As a therapeutic measure its use at present is entirely experimental, and a great deal of animal experimentation remains to be done before it can be accepted generally as of any more than psychological value in the treatment of silicosis."

CIGARET HABIT

To the Editor:—Please supply recent information on management of the tobacco habit. What can be done to stop the use of cigarets?

P. H. Schofield, M.D., Williamsport, Ind.

ANSWER.—Little can be done to stop the use of cigarets by a free adult who enjoys the practice. Parenteral injunctions, penalties and prohibition appear alike ineffective. Provision of special smoking compartments and facilities for disposal of burning cigarets seem more effective than "No Smoking" signs in lessening fire and other hazards. Although the pleasures of smoking may be diminished by rinsing the mouth or swabbing the throat with 0.5 per cent silver nitrate, even this may fail with confirmed smokers. Under some conditions substitution of a pipe for cigaret may lessen fire hazards or other disadvantages while yielding the same or similar physiologic consequences.

Persuasion and the development of personal conviction against the use of tobacco as a result of religious teaching, and consideration of financial disadvantages of smoking, from the cost of the habit and fire and other consequences of it, and particularly emphasis on the effect of tobacco on physical efficiency may go far to offset the advertising propaganda of commercial interests. Deleterious effects of tobacco on growth of minors and on athletic prowess are widely accepted arguments against smoking by adolescents. The literature and scientific data regarding effects of tobacco on physical efficiency were summarized by Schrumpf-Pierron (New York, Hoeber, 1927) and by Bogen (in Fisher, I., and Emerson, H.: How to Live, ed. 20, New York, Funk & Wagnalls Company, 1938).

It is much easier to abstain from smoking completely than to stop the practice after it has once been practiced. The person who is desirous of stopping cigaret smoking may reinforce this intention by reading the literature on studies on tobacco and may secure entertainment and suggestions from reading accounts of successful exsmokers. Eating candy or otherwise raising the blood sugar may compensate for lack of the habitual adrenal stimulation from nicotine and so overcome the acute symptoms of deprivation such as tremors and nervousness suffered by some smokers soon after cessation of the habit. Chewing gum, camomile or gentian root, or the use of cigarets with low nicotine content such as denicotinized cigarets and particularly the newly developed cigaret naturally low in nicotine, may satisfy the conditioned reflex or habitual urge to handle or touch a cigaret while the subject avoids the effects of the alkaloid itself.

ECZEMA

To the Editor:—Please give a brief definition of the terms eczematous dermatitis and eczematoid dermatitis.

M.D., Pennsylvania.

ANSWER.—An eczematoid eruption is one that resembles eczema; eczematous refers to one that is affected with or of the nature of eczema. A patch of psoriasis, for example, is not eczematoid; yet from overtreatment it may become eczematous. Dermatophytosis is usually eczematoid, although it, too, may become eczematous. The distinction between eczematoid and eczematous dermatitis, if any, cannot be explained readily because the question is still being debated whether or not eczema and dermatitis are the same disease. According to Sutton, all cases of eczema are, to the pathologist, dermatitis. "Eczema" implies chronicity, a tendency to recurrence, an element of idiosyncrasy, and the absence of complete etiologic analysis. The dualist school, however, always refers to sunburn as an example of dermatitis which is certainly not eczema. The tendency in recent years seems to be to regard eczema as an inclusive term much like rheumatism, and to regard all cases, whether solved etiologically or not, as examples of dermatitis. There are many physicians, however, who challenge this concept.

MYOPIA

To the Editor:—Is there value in exercising the eye muscles in cases of myopia or advantage in keeping severely myopic eyes undercorrected? Should full correction ever be attempted?

Harry Epstein, M.D., New York.

ANSWER.—Muscle exercises and visual training programs for the improvement of vision in myopia were reviewed recently by Hildreth and others at Washington University (*Am. J. Ophth.* 30:1563, 1947) and Woods at Johns Hopkins (*Am. J. Ophth.* 30:28, 1946). In each group of myopes about 25 per cent of the patients studied showed a low grade improvement in reading ability following training, but the change was within the limits of error of subjective testing. The maximum benefit was obtained by those who initially had visual acuity less than was expected from their refractive errors. The exercises were valuable in producing a psychologic change in some patients, convincing them that they saw better and with greater satisfaction to themselves, although there was no change in measurable visual acuity. These patients showed no diminution in the basic underlying myopia, and the improvement probably occurred at a level rather than an ocular level. Woods concluded that the exercises educated some patients to interpret blurred retinal images more carefully and convinced others that they saw better, although there was no measurable improvement. He decided that visual training was not otherwise valuable in myopia.

There is no advantage in undercorrecting myopia except in patients with over 20 D. in whom there is frequently no improvement in vision with greater correction. Myopes should receive the smallest correction that will give them maximum vision; this is usually the full correction as found on examination with cycloplegia.

CONGENITAL SYPHILIS

To the Editor:—A woman discovered four years ago that she had congenital syphilis. A physician treated her with heavy metal compounds for three years. Her Wassermann reaction has remained strongly positive. The blood reaction of the husband is negative.

1. Spinal fluid and colloidal gold curves as well as roentgenograms of the patient's cardiovascular system are negative. What course of treatment should be followed at this time? 2. What advice should be given this couple concerning the question of child bearing? 3. What course of treatment should be followed if this patient becomes pregnant?

M.D., Pennsylvania.

ANSWER.—Serologic tests of the blood of a patient who has congenital syphilis may give positive results for many years, and yet the patient may never display clinical evidence of activity of the disease. The negative results of examination of the cerebrospinal fluid and of a cardiovascular examination, and the fact that this patient had three years of treatment, although the extent of it is not stated, suggest that the positive results of serologic tests in this young woman are not of great importance. No mention is made as to whether she has had interstitial keratitis or other manifestations of congenital syphilis. If she has not had any manifestations of these complications to date, it is not necessary to treat her simply because of the positive reactions to serologic tests. This suggestion is based on the statement that the patient had three years of treatment with heavy metal compounds and has no clinical manifestations of the disease.

It is extremely rare that a congenitally syphilitic woman transmits the disease to her children. In fact, it is so rare that when it occurs it is considered to be a clinical curiosity. For this reason and the fact that penicillin is so valuable in the prevention of congenital syphilis, there would be no objection to this young woman's having a child. If she becomes pregnant, she should receive, as a precautionary measure, one course of penicillin administered at the end of the first trimester and another at the beginning of the third trimester. Patients of this type are not infectious, so that the possibility of transmitting the disease to her husband may be ignored.

VERTIGO FROM STREPTOMYCIN

To the Editor:—What therapy will hasten recovery from the loss of equilibrium brought on by streptomycin during treatment of subacute endocarditis? Treatment with streptomycin was given continuously for 6 weeks and was stopped two months ago. Improvement in the labyrinthine vertigo has not occurred and other causes for the vertigo cannot be found.

G. D. Bullock, M.D., Inwood, Ia.

ANSWER.—Known specific treatment of value for the vertigo resulting from streptomycin therapy is lacking. Intensive effort to get the patient to adjust to this dysfunction by walking exercises is suggested.

CHRONIC CYSTIC MASTITIS

To the Editor:—A woman, 27, with 1 child 5 years of age, has breasts so painful that she can hardly bear the touch of her clothes against them. This pain lessens during her periods but increases several days afterward and lasts through the following weeks. The only substance which has helped her is male hormone, as "linguets"; these completely relieved her at first, but lately they seem to have no effect. Please suggest treatment. Clement H. Arnold, M.D., Palo Alto, Calif.

Answer.—Chronic cystic mastitis with mastodynia is usually considered to result from a relatively excessive estrogenic hormone elaboration by the ovaries. This may be due to an absolute increase in estrogen secretion, a lack of normal destruction of estrogen by the liver through a vitamin B complex deficiency or an imbalance between the estrogen-progesterone ratio as secreted by the ovaries. If there is evidence of a nutritional deficiency it is suggested that large doses of vitamin B complex be administered. Otherwise, the most successful therapy is through the use of male hormone. It is suggested that adequate doses of male hormone be administered, such as 10 mg. of methyl testosterone by mouth daily for about two months, or 25 mg. of testosterone propionate once or twice a week by injection for at least two months. It is more than likely that the patient will be relieved of her painful breasts for at least a number of months. If there is a resumption of her discomfort, another course of androgen therapy is justified. If the dosage of androgens is less than 200 mg. per month by parenteral administration or 300 mg. per month by the oral route, dangers of virilism are rather slight. If changes do occur, however, such as acne, hoarse voice or hirsutism, a reduction in dosage level should be made.

SPEECH DEFECT

To the Editor:—A male child, 8 years of age, is apparently normal except for a speech defect which is more pronounced in words beginning with the letter "c." For example, he pronounces "city" as "tity." I have told the parents that he will improve with age, and also suggested a speech correction school. I do not believe he needs psychiatric treatment. Please advise where this child could be sent for treatment. Is there any treatment that can be used at home?

Oscar A. Kafer, M.D., New Bern, N. C.

Answer.—Such cases should be analyzed by experts if they have any degree of severity, but it seems probable that this 8 year old child is merely talking baby talk. He is getting considerable attention from his mispronunciation of words, and if the parents, children and teachers will not nag him about it and will relieve the tension, it will probably clear up. If not, he should be sent to a Child Guidance Clinic. A new Directory of Child Guidance Clinics is to be published soon by the National Committee for Mental Hygiene, 1790 Broadway, New York, and if the child has not improved in six months, the directory will then be available, and the child can be sent to a clinic. If the child is of average intelligence, the best treatment for this condition would be wholesome neglect of the symptom. To send him to a clinic at present, or to a speech correction school, would be like using a sledge hammer to drive carpet tacks.

VITAMIN B_1 IN POLIOMYELITIS

To the Editor:—What is the value of intraspinal injections of vitamin B_1 in acute poliomyelitis? Since thiamine hydrochloride (vitamin B_1) given intraspinally has been shown to have a specific stimulatory action on the respiratory centers, and is essential for nerve function, should this method of treatment not be given further trial, especially in bulbar types of poliomyelitis with respiratory paralysis? What objections are there to the intraspinal use of vitamin B_1 in the convalescent stages of this disease, particularly in those victims confined to iron lungs?

Elias L. Stern, M.D., San Diego, Calif.

Answer.—N. Greve (*Ztschr. f. Krüppelfürsorge* 32:102, 1939) and S. Stone (*Arch. Phys. Therapy,* 24:350, 1943; *J. Pediat.* 22:142, 1943) have published reports on intrathecal injections of vitamin B_1 in the therapy of poliomyelitis. The latter author combined artificial fever with vitamin therapy. One possible reason why this form of treatment has not been tried more extensively is the total lack of evidence in its favor from animal experiments. Deficiency of thiamine has not been found to increase susceptibility of animals to the experimental disease. Actually, thiamine deficiency increases the resistance of mice. It does not appear to affect the resistance of cotton rats or of monkeys.

Evidence is not available that thiamine, given in excess of the normal requirement, could do any harm during the convalescent stages. The only objections that might be raised are the uncertainties with respect to (*a*) any beneficial effect and (*b*) the advantage of administration by the intraspinal rather than other routes.

DIATHERMY WITH ROENTGEN RAYS

To the Editor:—I have been told that it was inadvisable to use short wave diathermy in the treatment of a patient who is being given roentgen therapy at the same time. Recently an excellent roentgenologist stated that diathermy and roentgen treatment could be used together and were sometimes synergistic. Which view is correct?

Charles J. Clark, M.D., Redlands, Calif.

Answer.—There is no authenticated evidence to support the contention that short wave diathermy nullifies the efficacy of roentgen rays. On the other hand, there is clinical evidence to support the contention that short wave diathermy enhances the effects of roentgen rays. For that matter, any agent that produces hyperemia, increases edema or increases blood flow enhances the action of roentgen rays by increasing the secondary or scattered roentgen rays in tissues. These soft radiations have a pronounced effect on the cells which they reach and add considerably to the incident roentgen ray beam reaching the tissues. The roentgenologist, however, has to take into consideration the additional increases in secondary radiations caused by the applications of short wave diathermy. This is essential in order to prevent overdosage and undue damage to tissues receiving both roentgen rays and diathermy.

COLD ALLERGY IN DROWNING

To the Editor:—Please give information on mechanism of cold allergy in cases of drowning. Alfred B. Sundquist, M.D., Manchester, Conn.

Answer.—The mechanism of cold allergy in cases of drowning is presumed to be on the same basis as other less serious or local types of cold hypersensitivity. The evidence indicates that in cold hypersensitivity of any degree there is a release of an excessive amount of histamine. This localized release of histamine results in localized vasodilation and edema and constitutes the common form of cold urticaria or angioneurotic edema. If the amount is great enough or if histamine is released from large areas of tissues a general histamine effect can be obtained. This may include flushing of the face, headache, gastric hypersecretion and lowered blood pressure. If the histamine release is still greater, profound depression of the blood pressure may ensue. This may result in fainting. It is understandable that fainting while swimming can result in drowning.

CANKER SORES

To the Editor:—In the discussion of the causes of canker sores, published in The Journal in Queries and Minor Notes, June 12, 1948, inadequate attention was given to food allergy, which is the commonest cause. Foods oftenest responsible for the various clinical manifestations of allergy, especially wheat, milk, eggs, fish, nuts, chocolate and certain fruits and vegetables, must be suspected. Many or even all fruits and tomato are often causative of canker sores. As in most chronic food allergies, cutaneous testing rarely implicates any or all of the allergenic foods. Therefore diet trial is required, for which my standardized fruit-free elimination diet has long been used with excellent results. The published menus and recipes should be given the patient (Rowe, A. H.: Elimination Diets and the Patient's Allergies: A Handbook of Allergy, second edition, Philadelphia, Lea and Febiger, 1944). Absolute adherence to the diet and the ingestion of enough of the foods to maintain weight are imperative. Ascorbic acid, 30 mg. daily, should be ordered as long as fruit is out of the diet. Other vitamins in harmony with the diet can be given after relief occurs. The diet must be continued longer than former periods of relief. After relief, foods may be added one by one, eliminating any which reproduce the canker sores.

With such diet trial I have found food allergy responsible for canker sores except in a few cases, in which bacterial allergy, arising from foci of infection, especially in the oral and pharyngeal cavities, and drug allergy at times have been responsible. The possibility of an electrolytic reaction between gold and amalgam fillings has been suggested in the literature and might require consideration in this case. Canker sores, moreover, occur in debilitated patients, but in them concomitant food allergy also may exist.

The exhaustion and drowsiness in this patient may be part of the syndrome of allergic toxemia due to food allergy, originally described by me and corroborated by Randolph (Ann. Allergy 5:418, 1948).

The possibility of food allergy in this patient certainly was not excluded. Cutaneous testing was done, but as stated, it rarely reveals the foods producing clinical allergy. Many reactions, moreover, are nonspecific or indicative of past or potential allergy. When canker sores or other allergic manifestations due to food allergy rapidly develop after the ingestion of food, such as walnuts, which frequently causes canker sores, then the cutaneous reaction may be positive. Usually, however, the food allergy is accumulative or delayed and the reacting bodies are minimal or absent in the skin. The dietary history at times is suggestive, but of limited help. Diet diaries, moreover, are of little aid, largely because of the refractoriness which often develops after an attack of clinical allergy such as asthma, headaches or canker sores, during which refractoriness the allergenic foods can be eaten without any symptoms for days or even weeks. Therefore only with the use of trial diets can food allergy as a cause of canker sores in a case of this sort be recognized and controlled in the great majority of cases. Albert H. Rowe, M.D., Oakland, Calif.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, SEPTEMBER—DECEMBER 1948

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1937. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

Acta chirurgica Scandinavica. Stockholm.
Acta Clinica Belgica. Brussels.
Acta medica scandinavica. Stockholm.
Acta Oto-Laryngologica. Stockholm.
Acta Paediatrica. Stockholm.
Acta Pathologica et Microbiologica Scandinavica. Copenhagen.
Acta radiologica. Stockholm.
Acta Tuberculosea Belgica. Brussels.
American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
*American Journal of Diseases of Children. A. M. A., Chicago.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Medicine. New York.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Cincinnati.
American Journal of Orthopsychiatry. New York.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Physiology. Baltimore.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine. Baltimore.
American Practitioner. Philadelphia.
American Review of Soviet Medicine. New York.
American Review of Tuberculosis. New York.
Anais Brasileiros de Ginecologia. Rio de Janeiro.
Anales Médicos. Mexico, D. F.
Anales de la Facultad de Medicina. Lima.
Anesthesiology. New York.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
*Annals of Otology, Rhinology and Laryngology. St. Louis.
Annales pediatrici. Basel.
Annals of the Rheumatic Diseases. London.
Annals of Surgery. Philadelphia.
Annals of Tropical Medicine. Liverpool.
Annals of Western Medicine and Surgery. Los Angeles.
Archiv für Dermatologie und Syphilis. Heidelberg.
*Archives of Dermatology and Syphilology. Chicago.
Archives of Disease in Childhood. London.
*Archives of Internal Medicine. A. M. A., Chicago.
*Archives of Neurology and Psychiatry. A. M. A., Chicago.
*Archives of Ophthalmology. A. M. A., Chicago.
*Archives of Otolaryngology. A. M. A., Chicago.
*Archives of Pathology. A. M. A., Chicago.
Archives of Pediatrics. New York.
Archives of Physical Medicine. Chicago.
*Archives of Surgery. A. M. A., Chicago.
Archivos Argentinos de Enfermedades del Aparato Digestivo y de la Nutrición. Buenos Aires.
Archivos del Hospital de Niños Roberto del Río. Santiago.
Archivos del Instituto de cardiología de México. Mexico, D. F.
Arizona Medicine. Phoenix.
Athena. Rome.
Australian Journal of Experimental Biology and Medical Science. Adelaide.
Australian and New Zealand Journal of Surgery. Sydney.
Blood. New York.
Brain. London.
Brasil-Medico. Rio de Janeiro.
British Heart Journal. London.
British Journal of Cancer. London.
British Journal of Dermatology and Syphilis. London.
British Journal of Experimental Pathology. London.
British Journal of Industrial Medicine. London.
British Journal of Ophthalmology. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Urology. London.
British Journal of Venereal Diseases. London.
British Medical Journal. London.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the Los Angeles Neurological Society. Los Angeles.
Bulletin of the New York Academy of Medicine. New York.
Bulletin of the U. S. Army Medical Department. Washington, D. C.
California Medicine. San Francisco.
Canadian Medical Association Journal. Montreal.
Cancer. New York.
Cancer Research. Baltimore.
Chirurg. Heidelberg.
Cincinnati Journal of Medicine. Cincinnati.
Connecticut State Medical Journal. Hartford.
Delaware State Medical Journal. Wilmington.
Deutsche medizinische Wochenschrift. Stuttgart.
Día Medico. Buenos Aires.
Diseases of Chest. Chicago.
Edinburgh Medical Journal. Edinburgh.
Endocrinology. Springfield, Ill.
Experimental Medicine and Surgery. Brooklyn.
Gastroenterology. Baltimore.
Geriatrics. Minneapolis.
Glasgow Medical Journal. Glasgow.
Hawaii Medical Journal. Honolulu.
Helvetica Chirurgica Acta. Basel.
Helvetica medica acta. Basel.
Helvetica Paediatrica Acta. Basel.
Hospital. Rio de Janeiro.
Illinois Medical Journal. Chicago.
Irish Journal of Medical Science. Dublin.
Journal of Allergy. St. Louis.
Journal of the Arkansas Medical Society. Fort Smith.
Journal of Aviation Medicine. St. Paul.
Journal of Bacteriology. Baltimore.
Journal of Bone and Joint Surgery. Boston.
Journal of the Bowman Gray School of Medicine. Winston-Salem, N. C.
Journal of Clinical Endocrinology. Springfield, Ill.
Journal of Clinical Investigation. Boston.
Journal of Endocrinology. London.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Gerontology. Springfield, Ill.
Journal of Hygiene. London.
Journal of Immunology. Baltimore.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Industrial Hygiene and Toxicology. Baltimore.
Journal of Infectious Diseases. Chicago.
Journal of International College of Surgeons. Chicago.
Journal of Investigative Dermatology. Baltimore.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Kansas Medical Society. Topeka.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal of Laryngology and Otology. London.
Journal of the Maine Medical Association. Portland.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal do médecin de Lyon. Lyon.
Journal of Mental Science. London.
Journal of the Michigan State Medical Society. Lansing.
Journal of the Missouri State Medical Association. St. Louis.
Journal of the Mount Sinai Hospital. New York.
Journal of National Cancer Institute. Washington, D. C.
Journal National Malaria Society. Columbia, S. C.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology, Neurosurgery and Psychiatry. London.
Journal of Neuropathology and Experimental Neurology. Baltimore.
Journal of Neurophysiology. Springfield, Ill.
Journal of Neurosurgery. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Obstetrics and Gynaecology of the British Empire. Manchester.
Journal of the Oklahoma State Medical Association. Oklahoma City.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of the Philippine Medical Association. Manila.
Journal of Physiology. Cambridge.
Journal of the Royal Army Medical Corps. London.
Journal of the South Carolina Medical Association. Florence.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Tropical Medicine and Hygiene. London.
Journal of Urology. Baltimore.
Journal-Lancet. Minneapolis.
Kentucky Medical Journal. Bowling Green.
Klinische Wochenschrift. Heidelberg.
Lancet. London.
Lyon chirurgical. Paris.
Maandschrift voor Kindergeneeskunde. Leyden.
Medical Annals of the District of Columbia. Washington.

*Cannot be lent.

Medical Journal of Australia. Sydney.
Medicina. Buenos Aires.
Medicine. Baltimore.
Military Surgeon. Washington, D. C.
Minerva Medica. St. Paul.
Nebraska State Medical Journal. Lincoln.
Nederlandsch Tijdschrift voor Geneeskunde. Amsterdam.
New England Journal of Medicine. Boston.
New Orleans Medical and Surgical Journal. New Orleans.
New York State Journal of Medicine. New York.
New Zealand Medical Journal. Wellington.
Nordisk medicin. Stockholm.
North Carolina Medical Journal. Winston-Salem.
Northwest Medicine. Seattle.
Occupational Medicine. A. M. A., Chicago.
Ohio State Medical Journal. Columbus.
Pediatria del Medico Pratico. Turin.
Pediatrics. Springfield, Ill.
Pennsylvania Medical Journal. Harrisburg.
Philippine Journal of Surgery. Manila.
Physiological Reviews. Baltimore.
Plastic & Reconstructive Surgery. Baltimore.
Policlinico. Rome.
Practitioner. London.
Praxis. Bern.
Prensa médica argentina. Buenos Aires.
Presse médicale. Paris.
Proceedings of Royal Society of Medicine. London.
Proceedings of the Society for Experimental Biology and Medicine. Utica, N. Y.
Proceedings of the Staff Meetings of the Mayo Clinic. Rochester, Minn.
Progrès médical. Paris.
Psychiatric Quarterly. Utica, N .Y.
Psychiatry. Washington, D. C.
Psychoanalytic Quarterly. Albany, N. Y.
Psychosomatic Medicine. Baltimore.
Public Health Reports. Washington, D. C.
Quarterly Journal of Medicine. Oxford.
Quarterly Journal of Studies on Alcohol. New Haven, Conn.
Radiology. Syracuse, N. Y.
Review of Gastroenterology. New York.
Revista Argentina de Cardiología. Buenos Aires.
Revista de la Asociación Médica Argentina. Buenos Aires.
Revista Clínica Española. Madrid.
Revista Clínica de São Paulo. São Paulo.
Revista Española de Pediatría. Zaragoza.
Revista médica de Chile. Santiago.
Revue de Rhumatisme. Paris.
Revue médicale de Liège. Liège.
Revue de la Tuberculose. Paris.
Rhode Island Medical Journal. Providence.
Rocky Mountain Medical Journal. Denver.
Sang. Paris.
Schweizerische medizinische Wochenschrift. Basel.
Schweizerische Zeitschrift für Tuberkulose. Basel.
Semaine des hôpitaux de Paris. Paris.
Semana Médica. Buenos Aires.
South African Journal of Medical Sciences. Johannesburg.
South African Medical Journal. Cape Town.
South Dakota Journal of Medicine. Sioux Falls.
Southern Medical Journal. Birmingham, Ala.
Southern Surgeon. Atlanta, Ga.
Strasbourg Médical. Strasbourg.
Surgery, Gynecology and Obstetrics. Chicago.
Surgery. St. Louis.
Texas State Journal of Medicine. Fort Worth.
Thorax. London.
Transactions of the Royal Society of Tropical Medicine and Hygiene. London.
Tubercle. London.
Union Médicale du Canada. Montreal.
United States Naval Medical Bulletin. Washington, D. C.
Urologic and Cutaneous Review. West Palm Beach, Fla.
Virginia Medical Monthly. Richmond.
Western Journal of Surgery, Obstetrics and Gynecology. Portland, Ore.
West Virginia Medical Journal. Charleston.
Wiener klinische Wochenschrift. Vienna.
Wiener medizinische Wochenschrift. Vienna.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.

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SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy	*Indust.—Industrial*
Am.—American	*Inst.—Institute*
A.—Association	*Internat.—International*
Coll.—College	*M.—Medical*
Commn.—Commission	*Med.—Medicine*
Comm.—Committee	*Nat.—National*
Conf.—Conference	*Pharm.—Pharmaceutical*
Cong.—Congress	*Phys.—Physicians*
Dist.—District	*Soc.—Society*
Div.—Division	*Surg.—Surgery*
Found.—Foundation	*Surgs.—Surgeons*
Hosp.—Hospital	*S.—Surgical*

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